United States Court of Appeals

for the

District of Columbia Circuit

TRANSCRIPT OF RECORD

BRIEF FOR APPELLANT AND APPENDIX

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 19,643

627

KATHARINE BAERMAN,

Appellant,

v.

JOHN ALFRED REISINGER, M.D.,

Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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QUESTIONS PRESENTED

1. Whether a physician who has treated a patient for years and who, after years of treatment, makes a tentative diagnosis that his patient has some impairment of her thyroid function, should use all of his medical knowledge and all of the laboratory techniques then available to confirm or rule out his tentative diagnosis of hypothyroidism?

2. Whether a physician's admitted failure, after making a tentative diagnosis, to use the laboratory techniques then available as an adjunct or help in reaching a final diagnosis which is admitted to be the accepted practice in the District of Columbia, is sufficient evidence to submit to the jury along with other evidence, on the question of negligence of that physician?

3. Whether a physician, who examined a patient over a period of six years and found symptoms of fatigability, drowsiness, sluggishness mentally which are admitted to be some of the early sumptoms of a lack of secretion of the thyroid gland, should have reached a conclusion that the patient had an impairment of thyroid function called hypothyroidism and immediately administer to her the proper treatment for that condition and whether his failure to do so would constitute sufficient evidence to submit the issue of negligence to the jury?

4. Whether a physician, who treated a patient for the same or concurrent symptoms to which the patient did not respond over a period of years, should have removed himself from the case or referred her to another physician for consultation before six years had expired and her condition became worsened to the point where consultation became imperative and whether the failure to do so would constitute sufficient evidence of his negligence to submit the issue to a jury?

5. Whether a delayed treatment of a patient for each of secretions from the thyroid gland because of an incomplete diagnosis constitutes

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United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

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BRIEF FOR APPELLANT

JURISDICTIONAL STATEMENT

This action is instituted by Katharine Baerman, a citizen of the United States now residing in the District of Columbia and is a civil action #3042-61 in tort for damages resulting from the negligence of the appellee. The case went to trial in the United States District Court for the District of Columbia on April 3, 1965. On April 7, 1965 there was entered on the Docket a verdict and judgment for the appellee upon directions of the trial judge. On May 25, 1965 the appellant was granted

leave to appeal without prepayment of costs and notice of appeal was filed May 17, 1965.

The jurisdiction of this Court is invoked by virtue of Sections 1291 and 1294 of the Act of June 25, 1948, Chapter 646 (62 Stat. 869, 929, 930); 28 USCA Sections 1291-1294 (1) relating to appeals.

STATEMENT OF FACTS

Appellant, Katharine Baerman, in 1947 was a civil service employee, then employed in Tokyo, Japan. In 1948 she returned to the United States for a heart operation (App. 8). She submitted to the operation "patent ductus arteriosis" (Tr. 32) at the University of California Hospital (Tr. 34). After she recovered from the operation, she came back east and secured employment at the George Washington Inn in the District of Columbia (App. 8). Her health was excellent and she didn't have to see a doctor until February 27, 1952, when she first went to see the appellee, John Alfred Reisinger, M.D. (App. 8). Her chief complaints were in the main that she was very fatigued, (App. 9) tiredness in setting up and working all day, etc.

Appellee, at the time, had been in the practice of medicine since 1926. He specialized in cardiology and he was an internist (App. 12); he had been an Instructor at the University of Pennsylvania teaching pharmacology and internal medicine in 1930 to 1936. In addition, he taught at Georgetown University in 1939 prior to the war (App. 12). He first examined the appellant on February 27, 1952 and after that examination reached a diagnosis, in part to the effect that the appellant's trouble was that she had a cardiac problem incident to a long standing patent ductus arteriosic and subsequent ligation which had imposed certain burdens on the heart. (App. 13) He defined a diagnosis as a medical nomenclature used to express a condition that exists in the patient (App. 13). That a clinical diagnosis depends upon clinical findings consisting of subjective findings related by the patient together

with objective findings made by the physician by listening, observing, and palpitation, as distinguished from laboratory findings (App. 13). In addition, he had recorded on his notes that the patient: "does not look anemic but get a blood count and to try more rest." (App. 13) Whereupon the appellee sent the appellant to the Kelso Laboratory to have a blood count made on March 14, 1952. He stated that the reason for use of the laboratory was as an adjunct or help when he could not determine what her condition was by his examination of the patient. (App. 14) The appellee then treated the appellant for anemia and a pelvic condition to which she responded. (App. 17) Thereafter he continued to treat her from 1952 to 1960; that her heart required no treatment (App. 16, 17). He made a tentative diagnosis in February, 1954, based on physical symptoms of fatigability, drowsiness, sluggishness mentally and menstrual irregularity related to him by the appellant, that appellant suffered from a possible loss of thyroid secretions and function. (App. 15) However, though he reached this tentative diagnosis he did not send her to the laboratory to determine whether he was right or wrong in the diagnosis. Accordingly, the appellant continued to receive treatment of vitamins and iron to build her blood up. (App. 9) She did not receive any further treatment for loss of thyroid secretions and functions until 1958, four years later. During which time the appellant's symptoms of tiredness, fatigability and sluggishness continued in spite of the vitamins and iron prescribed for her by appellee. Appellant became restless and in June of 1958, because she saw she wasn't getting along very well, she suggested to the appellee that maybe her illness was not in his field, that maybe it would be better if she went to a specialist or an internist (App. 10). But the appellee told her he was an internist (App. 10) and he continued to prescribe vitamins, iron preparations, and medicines for colds and respiratory infections (App. 10)— all of which the appellant took. The appellee continued to prescribe these medicines for appellant and to observe her for possible changes in her heart that might require treatment

(App. 16). He never told the appellant about his impressions as to her physical symptoms and continued to observe and treat her in this manner until after she had pneumonia in February, 1958. (Tr. 43) Then appellant had difficulty with her voice and throat (Tr. 46), her face became puffy, so the appellee finally referred her to another specialist in the field of internal medicine, who made a physical and laboratory examination upon her on or about September 22, 1958. After these examinations he made an immediate diagnosis that the appellant had myxedema. (App. 14)

Appellant, when she learned she had myxedema, returned to the appellee to find out what it meant (App. 10). At that time, the appellee advised her that myxedema was another name for hypothyroidism and that there were no miracles and that the appellant would have it for the rest of her life. (App. 10) At the trial he stated that the term myxedema is often used for the more severe grade of hypothyroidism and and that there are many degrees of thyroid insufficiency. (App. 18)

Appellant, before contracting pneumonia in 1958, was working for Hill and Sanders as a switchboard operator (App. 8). She worked in an office in an old garage type building which was drafty and thought the pneumonia was caused by her working conditions and that the myxedema was just a follow-up of the pneumonia. (App. 11) Accordingly, she put in a claim for Workmen's Compensation and at the hearing on her claim in March of 1961, she subpoenaed the appellee to testify at the hearing. (App. 11) It was at this hearing that she learned for the first time that the appellee had diagnosed hypothyroid condition as far back as 1954. And had not treated her for it.

In the following year, the appellant instituted this action in tort against the appellee for negligence which ended in a directed verdict in favor of the appellee from which this appeal followed.

STATEMENT OF POINTS RELIED ON

1. The Court erred in excluding medical testimony of a general practitioner because he is not a specialist in the field of internal medicine and then granting appellee's motion for a directed verdict on the ground that no direct expert evidence was presented on whether appellee's treatment did not conform to accepted standards of medical practice in the District of Columbia.

2. The Court erred in granting defendant's (appellee herein) motion for a directed verdict at the close of the plaintiff's (appellant herein) evidence which clearly raised questions of fact for the jury to determine on the issue of negligence.

3. The Court erred in denying appellant's constitutional right to a trial by jury on factual questions as to whether the appellee was negligent in his admitted failure to use available diagnostic techniques to aid him in reaching an accurate diagnosis of appellee's illness and to follow such accurate diagnosis with proper treatment for such condition.

4. The Court erred in denying appellant's constitutional right to a trial by jury on factual issues as to whether appellee was negligent in treating appellant for over four years, when such treatment was based on an admitted incomplete diagnosis.

5. The Court erred, by granting appellee's motion for a directed verdict, in that by so doing the Court denied appellant's constitutional right to have a jury as to whether failure of a physician to treat a suspected impairment of thyroid gland function of the appellant while admitting knowledge of the proper function of the thyroid gland, and that treatment by medicine is available to a patient who is solely under the physician's control and whether negligence may be inferred without further direct testimony of experts.

SUMMARY OF ARGUMENT

The trial court erroneously excluded, in a large part, evidence proffered by the appellant through one of her witnesses, who was in the general practice of medicine in the District of Columbia, and who had examined and treated his share of patients with hypothyroid deficiency and who examined and diagnosed the illness of the appellant on May 10, 1961. The exclusion of his testimony was based upon the fact that he was not an expert in the field of internal medicine. The exclusion by the Court of the evidence designed to prove negligence and then take the case away from the jury on the ground of insufficient evidence of negligence was error. It is well known that the law of torts is concerned with the adjustment of conflicting interests of individuals to achieve a desirable social result and is, therefore, in large part a battleground of social theory based upon a weighing the magnitude of the risk of harm against the utility of the actors' conduct. It is often called the reasonable prudent man concept acting under a particular set of circumstances. Thus an adult is said to have a greater duty towards a fellow man than a child, and adults with superior skill and knowledge such as a physician is required to exercise an even higher degree of skill and care than the ordinary layman. Yet every lawyer today knows that he must advise his client that physicians as a class are practically, though of course not legally, immune from judgment because of the difficulty of obtaining medical proof from other physicians as to his fellow practitioner's negligent acts or conduct. In malpractice cases the physician has all of the advantage of position, both in knowledge and a failure to impart his knowledge to his patient. The patient can't testify and the physicians won't except in rare instances.

The injustices which a patient in some instances suffered has caused the courts to give a wider latitude to the juries and relax the rule on medical testimony to a degree. That in some cases it is com-

mon knowledge that certain medical practices might result in harm to the patient and therefore the facts alone may raise a question of negligence to go to the jury.

The appellee in the case before us admitted that early during the period that he treated the appellant he suspected impairment of her thyroid gland but that he did not send her to a laboratory to determine whether she did or did not have it nor did he put her on a course of therapy treatments until 1958—some four years later when it became obvious that he would have to do something. Accordingly, he sent her to a laboratory specializing in internal medicine on September 28, 1958, and the appellant's illness was immediately diagnosed and she was placed on a course of therapy treatment for her myxedemous condition resulting from loss of the secretions from her thyroid gland.

Appellant maintains that these admissions alone establish a question of want of proper skill and care on the part of the appellee herein, and that it was error to take the case from the jury. Moreover, appellant maintains that even though the Court would not let her witness testify as to certain acts of negligence on the ground that he was not a specialist in the field of internal medicine that nevertheless the standard of practice was sufficiently established by three other doctors who testified as to their individual procedures of treatment and diagnosis in similar instances and that therefore this Court should reverse the trial court's decision and remand the case for a new trial.

ARGUMENT

I.

The Court Erred in Excluding Medical Testimony of a General Practitioner Because He Was Not a Specialist in the Field of Internal Medicine and Then Granting Appellee's Motion for a directed Verdict on the Ground That There Was No Evidence Presented as to Whether Appellant's Treatment Did Not Conform to Accepted Standards of Medical Practice in the District of Columbia.

Louis P. Levitt, M.D., a witness for the appellant, is a physician in general practice in the District of Columbia, who has in his practice treated patients with hypothyroid conditions. (App. 21) He testified that in his practice he considered the most important function of a physician in treating a patient to be: first, to establish a diagnosis by proper physical examination, and then to prescribe proper medications for the individual. (App. 22) The reason for establishing a diagnosis first, was so that proper medication might be prescribed for the sickness that the individual has. (App. 22) He testified he examined the appellant on May 10, 1961 and diagnosed her condition as an underfunctioning thyroid gland. (App. 24) A certain hypothetical question was then presented to him, setting forth among other things, that in 1954 you suspect the patient had a deficiency in the thyroid gland but did not send the patient to a laboratory to discover if she did or did not have that condition, but continued to treat the patient for anemia and respiratory infections. Then asking him whether he had an opinion with any reasonable degree of medical certainty as to whether the treatment would be accepted practice in the District of Columbia? To which the appellee objected and was sustained by the Court. (App. 24) Apparently on the basis that he could not answer hypothetical questions because he was a general practitioner and not an expert in the field. (App. 25)

The doctor was then asked a series of question as to whether he, in his practice, used the laboratory as an aid to determine the condition of hypothyroidism? (App. 24-26) Whether it was accepted practice in the medical profession in the District of Columbia to fail to treat a specific illness for a period of four years? Whether it was accepted medical practice in the District of Columbia to use the laboratory to assist the practicing physician in reaching a final diagnosis? (App. 25) Whether it is accepted practice in the District for a Doctor treating a patient to make diagnosis before embarking upon a treatment for any illness? Whether it was accepted practice in the District for a Doctor to use all of his medical knowledge to a patient's physical complaints constructively in the interest of the recovery of the patient? Whether it was accepted practice in the District for a Doctor to carry a study of a patient's illness far enough to make a positive diagnosis of the ailment? And whether it was accepted practice for a medical practitioner in the District to guess at a disease when he could know by the use of the laboratory? (App. 26-27)

Objections were sustained by the Court to all of these questions. We submit that it was error for the Court to do so and then direct a verdict in favor of the appellee because of insufficient medical proof. This Court, a long time ago in the case of *Gunning v. Cooley*, (1929), 58 App. D.C. 304, 306, 30 F.2d 467, aff'd, 281 U.S. 90, 94, 50 S. Ct. 231-234, upheld the trial judge who permitted an ear specialist to answer a hypothetical question presented to him which called for an answer, based on both the personal knowledge of the witness, who had treated the patient, and on assumption supported by the evidence already introduced. In this case the plaintiff had gone to a physician in general practice with a sore throat and received treatment for it. On her second visit he advised treatment of her nose which caused her sore throat from breathing through the mouth — he treated her nose. She next went to him with a slight cold and told him she had wax in

her ear. The Doctor in general practice then put sweet oil into her ear. There were several unmarked bottles in his cabinet and he apparently had used the same dropper for all the bottles. When he put the drops in her ear she became dizzy and suffered extreme pain in her ear. She was deaf for a time and she consulted an ear specialist. At the trial the Doctor testified he had put a couple of drops of mineral oil in her ear. There was no proof to the contrary, but the plaintiff apparently had claimed that the Doctor had put some acid substance in her ear. The ear specialist, who testified, had not made up his own mind as to the cause of the injury to the ear. The Court submitted the question to the jury and the plaintiff was awarded a verdict against the Doctor.

We submit that while, in the instant case, the positions are reversed, that nevertheless the same principle applies to this case. Doctor Levitt is in general practice; the appellee is a specialist in cardiology and claims to be an internist as well. (App. 12) Both apparently have treated the usual number of patients with impaired thyroid glands. Both then would appear to be competent to testify concerning the same conditions, both had experience in their respective practices. To say that a physician in general practice cannot answer a hypothetical question based on his examination of the appellant and his knowledge gained in his general practice would seem to be based upon a false premise, the effect of which is to make it more difficult for one instituting a malpractice action to sustain the burden of proof.

While there was no evidence as to what the Doctor put in the patient's ear besides the mineral oil, still from the unmarked bottles and use of the same dropper for all of the bottles, the jury was allowed to infer that there was some harmful substance put in the patient's ear and award a verdict for the plaintiff. The Court in its opinion in 58 App. D.C. 305, stated the rule on evidence insufficient for the jury to be as follows:

> "In other words it is only where all reasonable men can draw but one inference from the facts that the question is one of law for the Court."

The Supreme Court in affirming the opinion in 281 U.S. 90, 94, 50 S. Ct. 231, 234, stated the rule in substance to be that the plaintiff was not required specifically to show what the physician did put in the patient's ear or that the treatment destroyed either of her eardrums or made her deaf. If the evidence was sufficient to justify a finding that the defendant negligently put a harmful fluid in her ears causing her pain and injury, the motion for a directed verdict was properly denied.

It would seem then, that the Court erred in two instances in the instant case, first in refusing to let Doctor Levitt answer hypothetical questions and in directing a verdict for the appellee on the evidence submitted by the plaintiff. Indeed, it would seem that the testimony of the appellant and the appellee alone raised sufficient questions for the jury in this case.

II.

The Court Erred in Granting Defendant's (Appellee Herein) Motion for a Directed Verdict at the Close of the Plaintiff's (Appellant Herein) Evidence Which Clearly Raised Questions of Fact for the Jury To Determine on the Issue of Negligence.

The law of torts, it is said, is concerned primarily with the adjustment of the conflicting interests of individuals to achieve a desirable social result as a result it is a battleground of social theory.

Negligence, as a separate tort, has received recognition for little more than a century. Its rise coincided in a marked degree with the industrial revolution. The standard upon which the law of negligence is based is determined by weighing the magnitude of the risk of harm against the utility of the actor's conduct. It has been defined as conduct which involves an unreasonably great risk of causing damage.

Negligence is conduct, and not a state of mind. It involves a standard of conduct which falls below a standard established by law for the protection of others against unreasonable risk of harm. The idea of risk necessarily involves a recognizable danger to a person or thing, based upon some knowledge of the existing facts. The standard required of an individual is that of the supposed conduct, under similar circumstances of the reasonable man of ordinary prudence.

One of the most difficult questions in connection with negligence is that which the actor is required to know. For example, an adult is required to know more knowledge of a recognizable danger than a child. On the other hand a person with superior knowledge, skill, and intelligence such as a physician over the ordinary adult, will be required to exercise conduct consistent with it. Upon this basis a physician, who is possessed of unusual skill or knowledge, must use care which is reasonable in the light of his special ability and information, and may be negligent where an ordinary person would not.

Suppose then that we were now told that henceforth physicians, or butchers, or coal miners, or automobile drivers could not be sued, could not be burdened with a judgment. We would immediately raise our voices and say: "Why that is outrageous. It's unfair. It's unconstitutional."

Yet every lawyer today knows he must advise his client in a malpractice case that doctors, as a profession, are practically, though of course not legally, immune from judgment. The reason for this is, as every lawyer knows, is that of carrying the burden of proof.

It is well known that doctors are usually unwilling to take the witness stand in a malpractice case to give expert evidence as to the care and skill used by fellow-physicians and required to be used by fellow-physicians in similar cases. As a result of this refusal of the medical profession to inform the Court as to matters within their specialty

when the case is one of alleged malpractice, many a victim of a physician's negligence has gone uncompensated, and other physicians are thereby permitted to depart from the recognized standards of skill and care without the risk of accounting to the victim.

While we all no doubt have maintained a boundless admiration for the medical profession so far as contributing to human health and happiness, we also base this admiration upon the premise that without health one has not the strength to squeeze the orange of existence to obtain the elixir of the joy of living.

But after paying this sincere tribute to doctors, we must not place them on a marble platform of impeccability and infallibility. They are human and therefore subject to all the foibles and weaknesses of the flesh which in their profession might occasionally manifest themselves through indolence, indifference, or carelessness in a particular field which requires the maximum of skill, attention, and care. And if one doctor is negligent in one instance, neither he, nor the rest of the medical profession needs to feel that this constitutes an adverse appraisement of their own skill or their own dedication to the health and welfare of man. Indeed, it is because of this skill and dedication that inspires us all and causes us to place our faith, our health, and welfare under their sole care and control. In doing so we give them all of the advantage of proof in those cases where they are careless.

As this Court has said in 1941 in the case of *Christie v. Callahan*, (1941), 72 U.S. App. D.C. 133, 124 F.2d 825, 828:

> "Malpractice is hard to prove. The physician has all of the advantage of position. He is, presumably, an expert. The patient is a layman. The physician knows what is done and its significance. The patient may or may not know what is done. He seldom knows its significance. He judges chiefly by results. The physician has the patients in his confidence, disarmed against suspicion. Physicians, like lawyers, are loath to tes-

> tify that a fellow craftsman has been negligent, especially when he is highly reputable in professional character, as are these defendants. In short, the physician has the advantage of knowledge and proof."

It is for this reason that it has become necessary for the courts to loosen the strict rule of expert testimony and hold, as they did in *Crist v. White*, (1933) 62 App. D.C. 269, 66 F.2d 795, where the plaintiff was injured from being struck by a motorcycle below the left knee and the physician applied two casts upon her leg but thereafter another surgeon had to operate on her leg. The declaration charged a breach of contract to properly perform an operation on her leg and the second in tort for breach of duty to exercise reasonable and ordinary skill in performing the operation.

A directed verdict at the end of her case was reversed with the Court ruling that in malpractice action, plaintiff's testimony based on surgeon's examination of x-ray photographs after operation was admissible to show surgeon asserted progress in cure, and in an action for malpractice, whether surgeon failed to exercise proper degree of skill and care in performing operation on leg was a question for the jury.

During the same year this Court in another important case, *Grubbs v. Groover*, (1933) 62 App. D.C. 305, 67 F.2d 511, cert. denied, 291 U.S. 660, 54 S. Ct. 377, 78 L. ed. 1052, wherein the plaintiff in her treatment submitted to three x-ray treatments, twice under the supervision of the Doctor with a nurse in the room at all times. On the third treatment the x-ray was turned on and the patient left to the mercy of the machine while both the Doctor and the nurse went into another room. At the close of the plaintiff's case a verdict was directed for defendant, but on appeal it was reversed with this Court holding that evidence that x-ray practitioner administered x-ray treatment of patient without remaining in the room or within hearing distance and a burn re-

sulted, made issue of negligence for jury in malpractice case. That it was common knowledge that application of x-ray not infrequently results in a burn.

The Court also stated that grant of a motion for directed verdict accepts as true every fact offered in evidence by plaintiff with reasonable inferences therefrom.

Applying these rules to the instant case who did not treat an illness which he thought existed in his patient was of itself sufficient evidence to submit the question of negligence to the jury, because it is common knowledge that the reason a patient goes to a physician is for cure.

The rule is stated by the United States Supreme Court in *Texas & P. Ry. Co. v. Cox*, (1892) 145 U.S. 592, 12 S. Ct. 905, that a verdict should not be directed by the Court, unless as a matter of law, no recovery can be had under any proper view of the facts which the evidence tends to establish.

This rule has no doubt guided our Appellate Courts in the case of *Christie v. Callahan*, (1941) 75 U.S. App. D.C. 133, 135, 124 F.2d 825, wherein it was held that facts in malpractice cases are primarily within the jury's function, and hence it must be given wide latitude. That circumstantial evidence may contradict and overcome direct and positive evidence, the limitation on the use of circumstantial evidence being inferences drawn therefrom must be reasonable, but that there is no requirement that the circumstances, to justify the inferences sought, negate every other positive or possible conclusion. That proof of negligence or causation need not be established by testimony so clear that it excludes every other speculative theory. Thus it was held that in a suit for malpractice against physicians specializing in x-ray work, for an alleged overdose of x-rays in treatment of a pilandial cyst, the statement of the physician to the patient's wife that unfortunately he

had given patient too much x-ray but that the patient would be all right, could be found by the jury to be an admission of want of proper care.

In the instant case the appellee admitted in his testimony that he suspected impairment of the appellant's thyroid gland functions (App. 15, 17) but he did not send her to a laboratory to aid him in this preliminary diagnosis. Why then, could not the jury in her case have found this to be an admission of want of proper care. It is not common knowledge that it is not approved medical practice to treat a patient without first making a diagnosis of her condition, or to make an incomplete diagnosis, or to use the laboratory as an aid to reach a diagnosis.

This Court in the case of *Young v. Fishback*, (1958) 104 U.S. App. D.C. 372, 373, 262 F.2d 469, held:

> "We think the Court erred in taking this case from the jury. Everybody knows, without being told by an expert, that it is not approved surgical practice to leave in a patient's body a small bit of gauze or a few threads therefrom, or any other foreign nonabsorbable substance, no matter how small. It was for the jury to say whether the defendant had left even a small piece of gauze or other foreign substance in the wound and had thus caused the abscess."

This case was an action against a physician by patient based on abscess which developed on scar after physician had performed an appendectomy. Plaintiff did not produce any direct testimony that a foreign substance was found in the course of the second operation, but relied upon the patient's own testimony and the testimony of his father, both reciting statements of the physician to the effect that a small piece of thread or gauze had been left in the wound. The physician denied making any such admissions, and said he found no foreign substance when he reopened the wound. This Court on appeal from a directed verdict stated that it could be inferred from the plaintiff's testimony that at least a small portion of or a few threads from a piece

of gauze had been left in the first incision by the doctor, and reversed and remanded the case for a new trial.

In another case the Municipal Court of Appeals for the District of Columbia in the case of *Ambrosie v. Monks*, (1951) 85 A.2d 188, held that in a patient's action against a dentist for alleged injury to tooth, it was sufficient for jury to find that the injury was caused by some act of dentist in extracting adjacent tooth. The Court in discussing the rule requiring direct testimony from an expert to prove negligence in a malpractice case on the question of the merits of a diagnosis and scientific treatment could not be determined by a jury without the aid of expert testimony said on pages 189-190:

> "However, there are exceptions to the rule that expert testimony is necessary in malpractice cases. In *Christie v. Callahan*, 75 U.S. App. D.C. 133, 136, 124 F.2d 825, 828, it was said: 'Generally the standard must be shown by experts and so must the departure from it. But there are cases in which the result of medical or surgical treatment, considered in the light of circumstances attending and following it, may warrant an inference of negligence.' In *Sweeney v. Erving*, 35 App. D.C. 57, 62, 43 LRA (NS) 734, affirmed 228 U.S. 233, 33 S. Ct. 416, 57 L. ed. 815, it was said: 'There are exceptional cases where the result of an operation performed, if unexplained, may warrant an inference of negligence'."

Thus the Court reversed the directed verdict in favor of the defendant dentist with instructions to grant a new trial even though the plaintiff had produced no expert testimony. The Court stated the reason on page 190 as follows:

> "We think it can be said as a matter of common knowledge that the extraction of a tooth, done in a reasonable carefully manner, will not ordinarily result in the fracture of an adjacent tooth. And we think this unusual or out of the ordinary result called for an expla-

> nation by Dr. Monks and that in the absence of such explanation it was error to direct a verdict in his favor."

In the instant case we have testimony from the appellee himself, Doctors Levitt, Rosen, Alpert, and Sweeney all testify that it is important to use laboratory aids to diagnose a disease unless to do so would so harm the patient, as to outweigh the benefit of knowing the disorder or its cause, all indicated that by replacement therapy, loss of thyroid gland functions can be restored. Yet, this appellee did neither though he knew or should have known both the disorder and medical treatment then commonly used in the District of Columbia.

We submit that such evidence alone, if unexplained raises clear issues of negligence in discovering and treatment of the appellant herein on the part of the appellee, and the directed verdict in favor of the appellee herein at the close of the appellant's case should be reversed and remanded for a new trial.

III, IV, & V

Errors Set Forth in Three, Four and Five, Relate Generally to the Failure of Appellee To Use Available Diagnostic Techniques Available To Aid Him in Making an Accurate and Complete Diagnosis of the Appellant's Illness During the Eight Years He Treated Her, His Negligent Treatment Thereof and of His Failure To Treat Her While She Was Under His Sole Control as a Patient, and Her Constitutional Right To Have the Jury Decide These Factual Questions, Even Without Medical Evidence of Specific Acts of Negligence on the Part of The Appellee From Other Experts in the Field.

We submit that the lower court erred in taking the case from the jury at the close of the appellant's evidence, no evidence having been produced by the appellee and directing a verdict in favor of the appellee and in holding in effect that the appellant had produced no factual evidence of negligence on the part of the appellee. We contend that

there was plenty of such evidence. We contend that the practicing physicians produced by the plaintiff used in their practice the aid of the laboratory to reach an accurate diagnosis of hypothyroidism. Dr. Kelso from Kelso laboratories testified that in 1954 there were two laboratory techniques then in use to aid in diagnosis of hypothyroidism and to determine the metabolic function, and thyroid disorders (App. 20-21, consisting of a basal metabolism test and the protein-bound iodone test. (App. 21)

Dr. Kelso also stated that the purpose of laboratory test has three basic reasons. One is for aiding in diagnosis; two, in treatment of the patient; and number three, prognosis as to how the patient may progress in his or her illness. (App. 20-21) And that the metabolic function of the thyroid gland was essentially the activity of the thyroid gland which is a prime organ for regulating the oxygenation process of the body. That as food is ingested, and all the other body functions, the thyroid is the prime gland which produces the enzymes and hormones that causes these oxygenating processes to occur. (App. 21) Dr. Rosen stated when the appellant was sent to the National Institute of Health where he examined, diagnosed, and treated her, he gave her the usual complete work-up. (App. 19) When he attempted to assess effectively her thyroid function, that objective tests were the use of the laboratory. An objective test is one which didn't require subjective interpretation on the part of a physician, that many parts of a physical examination would be a subjective test. That a laboratory determination would be a blood test, examining circulating thyroid, hormone, x-ray determination of how much radioactive iodine uptake in the area of a person's thyroid gland, etc. (App. 19). He further testified that the purpose of the objective tests was to eliminate subjective error as far as possible. That hypothyroidism is an ancient disease. That myxedema is treatable, and, that it is desirable to catch every condition in a patient as soon as possible. (App. 19)

Dr. Levitt testified that the most important function of a doctor's treating a patient was first, to establish a diagnosis by proper physical examination, and then prescribe proper medication for the individual. (App. 22-23) That the purpose of the diagnosis before treatment is begun was so that the proper medication might be prescribed for the sickness that the individual has. That there are two approaches relating to whether a patient does or does not have hypothyroidism. One is the physical examination and the signs and symptoms the patient presents; and secondly, any other laboratory procedures which may benefit the doctor in prescribing for the patient. (App. 23)

Dr. Alpert testified he was a specialist in internal medicine (App. 27). He stated in response to a hypothetical question that if the clinical suspicion or clinical impression of a doctor, as to the status of the thyroid gland was strong enough that the patient had hypothyroidism, that most of the time he would have a laboratory test done unless there were certain factors which would contra-indicate it or make it unnecessary (App. 29). That if a doctor has a high degree of assurance in the sum total of his own condition of the patient suffered from it, it would become incumbent upon that doctor to take all steps available to treat that patient, if there were no other factors which conceivably might mitigate against administration of thyroid. (App. 29) He stated that the purpose of a laboratory examination was to clarify or confirm a clinical impression with regard to the diagnosis. That in the case of appellant, his laboratory examination confirmed his diagnosis of hypothyroidism. (App. 30)

Dr. Sweeney testified that he determined whether a patient has hypothyroidism first of all, clinically, by history, and the physical examination of the patient, and secondly, by laboratory tests, appropriate laboratory tests which are available at the time, meaning the appropriate laboratory testing of the function of the thyroid gland. (App. 31) That he would use the thyroid function to confirm the clinical impres-

sion that a patient was not adequately producing her own thyroid. It is a test I would use to confirm any clinical impression. That after he confirmed it, he would appropriately treat the patient. That in case of thyroid deficiency that it was important to determine the fact and to put the patient on treatment as soon as possible, depending on whether it would be in the best interests of the patient to have it completely replaced. That such procedure would be ordinary practice in the District of Columbia. (App. 31)

It might be argued that the individual practice of individual doctors does not establish the established procedures of skill and care in the District of Columbia, but we submit that such argument is based upon a false premise. Surely individual practitioners, all four of them, would not practice contrary to the established practice and all four, using the same procedure surely would present sufficient evidence of practice in the District of Columbia for the jury to determine the issue. In any event, it would seem to call on the appellee to go forward in his own defense to explain why he did not follow the same procedure, this would seem to be especially true where the appellee has expressly admitted knowledge of the procedure and practice of other physicians.

We not only contend that the Court erred directing a verdict in favor of the appellee at the close of the above-stated evidence from other physicians, three of whom practice in the District of Columbia. We contend that there was sufficient evidence upon the appellee's own admitted failure to follow through on his own diagnosis, was negligence. Especially in view of his admitted knowledge of the function of the thyroid gland, the symptoms usually present in the patient and their presence in the appellant during the eight years that he treated her. By his failure to follow through on his own diagnosis or treat her appropriately, the appellant was left alone to the mercy of her God, to suffer the expense and anxiety of a disease of which she had no knowledge but for which the appellee impliedly agreed to use his superior and special knowledge to ascertain its cause and to treat her therefor.

It is well known to every layman, and it is not necessary for an expert to tell us so, that an untreated disease often causes patients to die and almost always becomes worse if it has any permanency in nature from lack of treatment. Yet in this particular case the plaintiff was left unattended, except for one brief treatment in 1954, for four and one-half years, while her hypothyroid deficiency slowly deteriorated into a myxedemous state. Indeed, she was left unattended while the only person within hearing distance of her calls for help was her doctor, the appellee herein, who had agreed to ascertain the nature of and treat her for her condition. It is almost inconceivable that though the judgment of the appellee told him in 1954 that appellant suffered, at least in part, from an impairment of her thyroid gland, and that the only proper treatment was by the use of a thyroid replacement therapy after proper laboratory tests were made to determine the extent and loss of its secretions; yet he callously ignored her cries for help, ridiculed her persistent cries and complaints and watched her thyroid deficiency deteriorate into its last stages before he finally acted 4-1/2 years later upon his own better judgment.

Under these circumstances can it be said that it was not the duty of the appellee to at least act to ascertain the accuracy of his own judgment in 1954 as to his patient's lack of thyroid secretions? Can it be said that a physician can prescribe a sugar-coated vitamin pill for a patient and charge her for his medical services with knowledge that it would most probably have no effect on her real trouble or lack of proper secretion of the thyroid gland?

The appellant submits that the answer should be no, and that any doctor so treating a patient would, by such actions, show a gross and reckless disregard for the safety of his patient, and a disregard of his dedication to his profession. This is so because the primary pursuit of the medical profession is not for the sole thought of making money, but for the health and welfare of mankind.

The appellee may argue that before this appellant can recover she must show by affirmative evidence, first, that this appellee was unskillful or negligent and, secondly, that this want of skill or care usually practiced in the District of Columbia by other physicians caused the injury to her; that the only admissible proof must come from a specialist in the field, and that if any element is lacking in her proof, she has presented no case for the jury. This appellant disputes this contention, but thinks that in the instant case she comes within the language stated. That the evidence shows not only negligence and want of skill and care but also a reckless disregard for her health for the appellee to conclude that her thyroid function was insufficient and fail to treat her for this condition or use any diagnostic technique available to determine the accuracy of his conclusion for that disease which his inner voice must have told him his patient suffered and for which he should be treating her.

All the evidence shows that there is but one successful treatment for the condition, that there is but one set of symptoms generally prevalent to point the condition, and one predominate procedure available to check out his conclusion for accuracy. Yet, he rejected all of them. Even when it must have been apparent that the treatment was improper or ineffective, and that his patient came back with the same symptoms, he did not refer her to another physician for consultation or examination until her condition became so bad it became imperative that he do so. It is significant that in 1958 when he finally referred the appellant to Doctor Alpert. One physical examination and one use of the laboratory verified the conclusion of myxedema, the end result of hypothyroidism. All the practitioners stated that it was ordinary practice in their profession for physicians to use the laboratory as an indispensable aid in discovering and treating patients with a deficient thyroid gland. Yet, because it was not used by the appellee in the instant case the appellant was caused to suffer years of anguish and

steadily worsening health because of the appellee's persistent failure to use such aids, either to discover or to treat this appellant's condition.

Having in mind the often repeated rule stated in the case of *Chalvet v. Huston*, 43 App DC 77, a verdict should be directed only where, accepting as true every fact offered in evidence by a plaintiff, with every reasonable inference deduced therefrom, a conclusion utterly opposed to plaintiff's right to recover would be reached by all fair minded men. We submit that all fair-minded men could not reach that conclusion under the evidence and facts in this case.

It was held in the case of *Teichman v. Parrish*, 1946, 81 US App DC 217; 157 F.2d 75, that the failure of a doctor to administer treatment himself but allowing his nurse to do so, he was responsible for her negligence and no expert testimony was needed. The patient in this case had warts removed from her left hand and leg. She entrusted the doctor to care for her. Doctor used acid to remove the warts and prescribed three treatments, the first two were successful and the doctor was present, but the third treatment was not successful. The doctor was not present but had left it to his nurse to apply the acid which ran over on the skin causing burns.

Another case *Winstead v. Hildenbrand*, (1946) 81 US App DC 368; 159 F.2d 26, wherein a patient was referred to a physician from Georgetown for injection of shots for cerebraspinal syphillis. The doctor accepted the referral but did not make an independent examination of the patient's eyes. Instead he relied on the abstract record from the hospital. Treatment consisted of some 9 or 10 treatments involving injections and placing the patient in a fever cabinet. The injections were of tryparsomide injections, which were extremely dangerous and usually required continuous eye examinations during treatment, which the doctor failed to do except to look at his eyes. After the 9th treatment the patient became ill and was removed to Garfield Hospital,

where it was discovered he was blind. The only expert testimony offered at the trial was a doctor who testified that he could not determine the cause of blindness.

On appeal from a directed verdict in favor of the doctor, the defendant argued that without expert testimony, plaintiff failed to prove a prima facie case and the Court should have directed a verdict for the defendant because the plaintiff was required to prove both negligence and the injury proximately resulting from such negligence. The plaintiff, on the other hand argued that the failure of the doctor to make an examination of plaintiff's eyes established negligence as a matter of law, since the doctor was aware of the dangerous quality of the drug and was not allowed to rely on the prior eye examination made at Georgetown Hospital.

This Court ruled that the evidence was sufficient to take the case to the jury on the question of negligence and proximate cause, and reversed the verdict and granted a new trial. Again in *Goodwin v. Hertzberg*, (1952) 91 US App DC 385; 201 F.2d 204, wherein it was held that in a malpractice action, facts alone may prove negligence, and, if so, it is unnecessary to have expert witnesses.

In this case it was held substantially, that it was necessary in performing operation on a woman, to use care not to perforate the woman's uretha. But the doctor during the course of the operation did perforate the uretha and he must have done so in the progress of the operation. No expert testified that the doctor was negligent. The case was submitted to the jury, who disagreed, the Court then directed a verdict for the doctor and refused to grant a new trial.

This case held that generally, direct and positive testimony of specific acts of negligence is not required in a malpractice action. Thus it was again held that facts alone may prove negligence without the aid of expert witnesses.

To the same effect it was held by this Court in *Garfield Hospital v. Marshall,* (1953) 92 US App DC 234, 204 F.2d 721, which was an action for injury sustained by a baby as an alleged result of hospital's negligent failure to provide proper care and attention during the mother's labor and delivery. The District Court rendered judgment for the plaintiff. On appeal this Court affirmed the verdict stating on page 240:

> "* * * there must be, in the nature of things, many instances where the facts alone prove negligence, and where it is unnecessary to have opinions of persons skilled in the particular science to show the unskilled negligent treatment. In *Bryons v. Eastern Dispensary and Casualty Hospital,* 78 US App DC 42, 43; 136 F.2d 278, 279 we said non-expert evidence of conditions, and results may be accepted in the question of negligence."

Again this Court in *Furr v. Herzmark,* (1953) 92 US App DC 350; 206 F.2d 468, wherein the plaintiff allowed the defendant to operate on his leg to shorten it to relieve back pains. In the operation metal plates were attached to the bones by the use of screws drilled into the bone. Apparently, one screw came loose making necessary a second operation. The Court ruled that while there was no showing of negligence in the operation itself there was a factual question of negligence by reason of the presence of the loose screw and metal plate — which caused the second operation to correct the defect. Stating that the case need not be decided solely on the basis of expert testimony, but that the factors set forth, without further explanation, would support an inference by the jury that defendant had not met the standard of judgment and skill of the community. In other words, that facts alone may prove negligence.

In the case of *Young v. Fishback,* (1958) 104 US App DC 372; 262 F.2d 468, it was held in substance that facts plus the statement of the defendant doctor was adequate proof of negligence without the aid of an expert.

In the surrounding areas the rule seems to be the same. In *Reed v. Church,* 175 Va. 284; 8 SE 2d 285, the State of Virginia held that a physician impliedly represents that he is keeping abreast of the literature and that he has adopted those techniques which have become standard, in his life of practice. That a physician is liable when a patient is injured without negligence on the part of the patient, as a result of the physician's neglect to exercise reasonable care and skill in making examinations and tests which are reasonable in order to diagnose the disease and his failure to exercise like care and skill to ascertain the probable effects of drugs prescribed and to observe the precautions if any are indicated. It would appear that this appellant would be entitled to such a ruling in the instant case.

In *Dietz v. King,* 184 F.Supp 944, it was held that where a surgeon left a sponge in operating wound after radical mastectomy operation, and had information after the operation which indicated to him the possibility of foreign body in the wound, but failed to reveal his suspicions to the patient, did not order or suggest an x-ray before the patient left the country, and did not make full disclosure to patient's other doctor, although he knew the patient was anxious to leave the country, it was held that that surgeon was guilty of negligence.

It was held also that it is a general proposition that a physician or a surgeon may be held guilty of negligence in failing to take an x-ray as an aid in diagnosis or treatment if, under the evidence, it is shown that according to the tenets of the physician's school of medicine, or the usual practice in his locality, the circumstances presented were such as to require the physician in the exercise of the skill and care with which he was charged, to resort to an x-ray examination.

In the State of Iowa, *Wilson v. Corbin,* (1950) 241 Iowa 603, 41 NW 2d 707, it was held that malpractice may consist of lack of skill and care in diagnosis as well as treatment.

This was an action against a physician for claimed negligent failure to diagnose and treat a fracture of the third lumbar vertebra, when x-ray picture was taken of only 4th and 5th lumbar vertebra, but physician assured plaintiff that nothing was wrong with him, it was held the evidence of negligence was sufficient to go to the jury.

That while a physician does not insure the correctness of his diagnosis, a patient is entitled to a thorough and careful examination such as his condition and attending circumstances will permit with such diligence and methods of diagnosis as are usually approved and practices by physicians or ordinary learning, judgment and skill in the community or similar localities.

A similar rule was put forth by this Court in the case of *Price v. Neyland* (1963) 115 App DC 355; 320 F.2d 674, wherein it was held that the evidence sustained finding that physician was guilty of malpractice in making mistake in his diagnosis and in the medical mismanagement in case of the child born of parents with RH factor blood incompatibility.

The Court stated that a physician is not liable for mistake in diagnosis or error of judgment except where the mistake results from failure to comply with recognized standard of medical care exercised by physicians in same specialty under similar circumstances in general area in which the physician practices.

The State of Iowa went farther in *Wambold v. Brock*, 236 Iowa 758; 19 NW 2d 582 holding that the failure to notify a patient of her condition in order that she might seek treatment elsewhere. That a physician owes in addition to ordinary skill and care in treatment owes reasonable care in the performance of his duties, and such includes giving advice to the patient as to her condition and whether he did or not was a question for the jury.

In the 7th circuit Federal Court, *Weintraub v. Rosen*, 93 F.2d 544 (1938), it was held that where physician treated a woman who sustained

a skull fracture in an automobile accident and was unconscious several days, but the physician failed to discover and treat her fractured hip, the Court improperly placed burden upon patient and her husband, in suit against physician for malpractice, to prove that patient was in fit condition to have her hip examined and cared for without endangering her life.

The Court held that proof of the failure to discover and treat the fractured hip established prima facie case of negligence and resulting damages, which put the burden upon the physician of proving his defense that condition of patient's head was such that examination and treatment of her hip would have endangered her life. That physicians owed injured patient duty of making such examination and giving such treatment as patient's physical condition and the skill of their profession warranted, on page 547 the Court said:

> "It is unbelievable that medical skill of the Springfield physician is not sufficient to enable them to discover and reduce a fracture. The record shows that the use of a gutter splint would have relieved the patient of some pain and would have kept the bones a little nearer together where some one might have a chance to do something with them later."

> "Assuming that the patient entered the hospital unconscious in shock, suffering from serious skull fracture, and while she was unconscious for several days she unconsciously rubbed her hip and groaned when she recovered consciousness she continued to rub her hip and groan, in my opinion I would rather think it would direct the attention of a reasonably skillful and competent physician to her hip. Under those circumstances, I would think that on that part of the body an examination would be required."

The Court then said that it could safely be said from the evidence that the appellees were negligent in not observing the condition of the patient's hip.

The State of New Hampshire in *Mehigan v. Sheehan*, (1947) 94 NH 274; 51 A.2d 632 held that a physician is liable to patient where physician acts from negligence and carelessness contrary to what must have been his better knowledge and judgment if he had given proper attention to the case, and that the question was one for the jury to determine.

The State of Missouri (1934) *Gunter v. Whitever*, 74 SW 2d 588 held that malpractice may result either from injury occasioned by a physician's want of requisite knowledge and skill, or from a physician's negligence, omission to have exercised due care in the application of skill and knowledge he possessed. That the propriety of the course of treatment followed by a physician is to be measured by standards existing at time of treatment.

In *Baird v. National Health Foundation* (1940) 235 Mo App 594; 144 SW 2d 850, it was held in a malpractice action against health association and physicians employed by it to render medical services to members, testimony of private physician who was a qualified medical doctor could be considered as that of an expert witness and his testimony, expert testimony, and so sufficient to make a case for the jury, even though the term expert was not used in connection with his testimony where that physician was requested by the plaintiff's husband to take over the case and diagnosed plaintiff's condition and administered treatment to which she responded favorably.

We submit that the instant case does not set up two different medical standards for measurement of the skill of the appellee herein, it does appear however, that he was negligent in failing to properly observe the progress of the appellant's condition, though he knew of its existence, or to advise himself of her condition or advise her of it. In short, we submit that there is sufficient evidence for the jury showing that he was negligent as a physician in this case and this is so regardless of his general skill and ability.

CONCLUSION

Accordingly, this case should be reversed with instructions to to grant the appellant a new trial on the merits.

JOHN J. SPRIGGS, JR.
614 Indiana Avenue, N. W.
Washington, D. C. 20004
Attorney for Appellant

INDEX

JOINT APPENDIX

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

KATHARINE BAERMAN
2715 Courtland Place, N.W.
Washington, D. C.
Plaintiff,

vs.

JOHN ALFRED REISINGER, M.D.
901 20th Street, N. W.
Washington, D. C.
Defendant.

Civil Action No. 3042-61

COMPLAINT IN MALPRACTICE

1. The defendant, at all times mentioned herein is a duly and regularly licensed physician under the laws of the District of Columbia holding himself out as an expert medical practioner.

2. The plaintiff, in 1952 and thereafter until August 2nd, 1960, employed the defendant as such medical practioner to cure her of an illness from which she suffered, and for that purpose defendant, for a consideration, undertook as an expert, to treat, attend and cure the plaintiff of her illness.

3. The defendant, after entering on such employment with the plaintiff, did not use care or skill in endeavoring to cure, treat or attend the plaintiff for her illness, he negligently and improperly treated her for the illness; he failed and negligently treated her, in that he failed to administer treatment for hypothyroidism which he knew or by the exercise of reasonable care should have known she had incurred; he improperly treated her for her illness, and/or negligently and incorrectly failed to properly diagnose her illness as he would have dis-

covered had he used the care and skill ordinarily possessed and used by medical practitioners in the District of Columbia, in addition, the defendant fraudulently and deceitfully concealed from the plaintiff all of the negligence aforesaid until the year 1961.

4. Plaintiff, during February, 1958, believing that she had contacted penumonia in the course of her employment due to improper working conditions. Upon her recovery it was believed that the infection caused hypothyroidism which destroyed the thyroid gland thereby leaving her permanently injured. Plaintiff thereafter submitted a claim to the Workmen's Compensation Commission for her disability and at the hearing thereon for the first time learned through the testimony of the defendant who opposed her claim, that her hypothyroid condition existed prior to the pneumonia and was not incurred within the scope of her employment.

5. That by reason of the defendant's negligence aforesaid the plaintiff has been permanently injured in that her thyroid condition is now incurable, she has suffered loss of compensation benefits, her health and all physical activity has been seriously curtailed, she is unable to obtain many types of employment due to her condition, her life span has been reduced and she suffered and is suffering extreme physical and mental anguish; she was obliged to, and did, incur hospital and medical and other expenses in endeavoring to be cured of her illness; her condition has been aggravated, she was incapacitated for one year as a direct result of the improper conduct of the defendant to the plaintiff resulting in damages in the sum of fifty thousand dollars ($50,000).

WHEREFORE, plaintiff demands judgment from the defendant in the sum of fifty thousand dollars, ($50,000), together with such other and further relief as to the Court may seem just and proper.

/s/ John J. Spriggs, Jr.
Attorney for Plaintiff
614 Indiana Avenue, N. W.
Washington, D. C.

Plaintiff demands a jury trial to determine the issues herein.

/s/ John J. Spriggs, Jr.

ANSWER TO COMPLAINT

Now comes the defendant, Dr. John Alfred Reisinger, by his counsel and for answer to plaintiff's complaint in the above designated cause, states:

FIRST DEFENSE

Plaintiff's complaint fails to state a cause of action upon which relief may be granted.

SECOND DEFENSE

(1) Defendant denies that he at any time held himself out as an expert medical practitioner. Defendant admits that he is a general practitioner of medicine and was so engaged at the times alleged in plaintiff's complaint.

(2) Defendant admits that he treated plaintiff as her general physician from time to time beginning approximately in 1952 for various general illnesses and ailments until approximately August, 1958.

(3), (4) and (5) Defendant denies each and every allegation of negligence alleged in plaintiff's complaint Paragraphs Three (3), Four (4) and Five (5) and denies concealment as alleged and denies that plaintiff has been injured and damaged as alleged by reason of any act or thing done by this defendant or any negligence on his part.

Defendant is without knowledge and information as to the allegations of Paragraph Five (5) of plaintiff's complaint with reference to her physical condition, alleged impairment, etc., and therefore, denies each and all of said allegations and demands strict proof thereof.

THIRD DEFENSE

Statute of Limitations. Defendant states that plaintiff's claim in the above-captioned case is barred by the Statute of Limitations in that the matters and things complained of, happened and occurred more than three years next past before the filing of this action, on, to wit, September 15, 1961.

WHEREFORE, defendant demands that plaintiff's complaint be dismissed and that he may have judgment against the plaintiff for his costs and expenses in this behalf.

WELCH, DAILY & WELCH

By: /s/ H. M. Welch
Attorneys for Defendant
505 Investment Building
Washington 5, D. C.

[Certificate of Service dated September 29, 1961]

PRETRIAL PROCEEDINGS

KATHERINE BAERMAN

JOHN ALFRED REISINGER, M.D. 3042-61

February 8, 1965

Action for damages due to malpractice.

THE PARTIES AGREE TO THE FOLLOWING STATEMENT OF FACTS AND STIPULATE THERETO:

D practices medicine as an internist in Wash., D. C. and has, during all pertinent times herein. P consulted him at various times in his professional capacity as a physician in the interval bet. 1952 and 1960.

PLAINTIFF CLAIMS that she sustained injuries, some of which are permanent, medical expense and other special damages listed herein, due to the negligence in treatment and failure to treat her and in his fraudulently and deceitfully concealing such negligence from P as follows: failed to give credence to P's observations, remonstrances, and the history related to him by P; failed to advise P of his suspicions as to her true condition as it existed in 1954, to wit: hypo-thyroidism; that although D suspected hypothyroidism in P as early as 1954, he failed to exercise the care and skill in treatment generally exercised by other physicians in this community under similar circumstances in that he never told her she had it, never gave her any treatment for it, never gave her a basal metabolism test until 1958, never gave her any thyroid extracts, failed to diagnose P's condition as hypo-thyroidism until 1958; delayed administering treatment to P for hypo-thyroidism and myxedema until 1958, all of which constituted improper treatment for P's illness.

Furthermore, D advised P that her condition was improving, when he knew or should have known just the opposite; that D stated to P that there was nothing wrong with her physically from 1956 to 1958, by his conduct inferring that her complaints were imaginary when he knew or should have known just the opposite.

PLAINTIFF'S CLAIMED INJURIES: Atrophy and disintegration of thyroid gland; hypo-thyroidism with myxedema; aggravation of a pre-existing heart condition; deterioration processes throughout P's entire anatomy, to wit, hearing loss, difficulty in speech, hoarseness and dryness of skin.

DEFENDANT denies any negligence and avers that he used ordinary and accepted standards of medical practice appertaining in the D of C at all material times.

D asserts that the matter complained of occurred more than three

years prior to the filing of this suit and is therefore barred by the statute of limitations.

CLAIMED SPECIAL DAMAGES:

Dr. Reisinger (approx. payments)	$ 500.00
Geo. Wash. Hosp.	15.00
Dr. Alpert	25.00
Dr. Feldman	15.00
Dr. Humphries	10.00
Wash. Hosp. Center (approx.)	550.00
National Institute of Health (approx. real value) in-patient for 3 weeks and out-patient until April 1961	1,100.00
Medicines (approx. $75 per year for 6-1/2 years)	487.50
Transportation to doctors (approx.)	150.00
Incidentals - lab, tests, x-rays, etc.	350.00
	$ 3,222.50
Loss of wages for 18 months - 1956 until 1960 - $60 per wk. or $250 per month	$ 4,500.00
Reduction in salary due to illness from Mar. 1960 through Dec. 1960 - $250 to 122.28 or 127.72 for 10 months	1,277.20
From Jan. 1961 through Dec. 1961 - $250 to $141.80 or 108.20 per mo. (12 mos.)	1,298.40
From Jan. 1962 thru Dec. 1963 - $250 to $152.78 per mo. or $97.22 per mo. for 24 mos.	2,333.28
From Jan. 1964 to present time - 14 mos. $250 to $171.24 or 78.76 for 14 mos.	1,102.04
	$10,510.92
GRAND TOTAL	$13,733.42

together with mental and physical pain and suffering from 1958 until death.

STIPULATIONS

The parties agree to file with the Clerk of the Court and to mutually exchange, on or before Feb. 20, 1965, a list of the names and addresses of all witnesses known to them, including medical and expert witnesses, who have knowledge of any aspect of this case, indicating those who may be used at the trial. Impeachment witnesses are not to be included.

The counsel for P agrees to furnish to counsel for D a written authorization, which will be supplied by D within 5 days, and returned to D on or before Feb. 20, 1965, which will enable D to obtain copies of P's federal income tax returns for the years 1957 to date.

The parties agree to the mutual exchange of all medical reports of examining or treating physicians, now in hand, on or before Feb. 20, 1965, and a similar exchange of all other such reports within 48 hours of the alert of this case for trial.

Counsel for P agrees to make the P available for the purpose of a physical examination by physician of D's choice before, but not to interfere with, trial.

Counsel for P requests that the HEW Mortality Tables be admitted in evidence but D, on the basis that P is not the average white American female, refuses to agree.

P's counsel intends to offer at the trial, the records of the National Institute of Health.

The Examiner has requested counsel for the parties to appear at trial with the maximum amount of authority to settle this case which will be allowed them by their principals.

TRIAL COUNSEL: Pretrial Examiner

J. J. Spriggs, Esq. for P H. Mason Welch, Esq. for D.

EXCERPTS FROM TESTIMONY

* * *

[27] Q. What is your name? A. Katharine Baerman.

* * *

[30] Q. Now, where did you work before you went to work at your present job? A. At Hill and Sanders.

Q. What was your occupation there? A. I was a switchboard operator and I did filing and other office work.

Q. Could you give us the year, the dates, the approximate dates? A. It would be from November of '57 until, I think, September of '58.

* * *

[32] Q. Now, going back to 1947, where were you employed? A. Forty-seven, I was with the Civil Service in Tokyo.

Q. And what was your reason for coming back from Tokyo to the United States? A. I had a heart condition that needed to be operated, and they said I should come back to the States to have it taken care of.

* * *

[33] Q. Did you have an operation? A. I had an operation later, yes.

* * *

[34] Q. When was that? A. That was in 1948.

Q. Now, after the operation, what did you do? A. After the operation I came back East and got a job.

Q. And where, where was that? A. That was at the George Washington Inn.

Q. What was the condition of your health after the operation in 1948, which you just spoke of? A. My health was excellent. I didn't have to see a doctor for several years.

Q. When did you first go to see Dr. Reisinger? A. February 27, 1952.

* * *

[35] Q. What were your complaints? A. The complaint was mainly that I was very fatigued, that I had a tiredness in sitting up and working all day, tired from my chest, -- general fatigue.

Q. What did Dr. Reisinger do? A. Well, he told me to try to get as much rest as possible. I don't know whether it was that time or later that he suggested I might be anemic.

Q. What did he do after that? A. He sent me to a clinic that was in the neighborhood there. It was Dr.Kelso's Clinic, and he took a hemoglobin test, that is, a blood test.

Q. I see. And then as a result of that blood test, what did you do? A. He gave me vitamins and iron compounds to build up my blood.

* * *

[36] Q. Now, did you go back to Dr. Reisinger after he gave you these drugs? A. Yes, I did.

Q. How often did you go back? A. I went often, I kept on being tired.

Q. How long did you continue to go to Dr. Reisinger for treatment? [37] A. I went to him from February '52 through the 2nd of January of 1960.

Q. Now, then, Dr. Reisinger, what treatment did he give you during this period? A. He was still giving me vitamins and iron to build my blood up.

Q. Now, did there come a time when you learned that you had myxedema? A. Yes.

* * *

[38] Q. When did you first learn that you had myxedema? A. When Dr. Louis Alpert told me at the Warwick Memorial Clinic for cancer and allied diseases.

Q. And do you remember when that was? A. That was in September of 1958.

* * *

[40] Q. Who told you you had myxedema? A. Dr. Alpert. I didn't know what it meant. I had to go to Dr. Reisinger to find out what it meant.

Q. And what did Dr. Reisinger tell you when you went to him? A. He said myxedema was another name for hypothroidism and that there were no miracles and I would have it the rest of my life.

* * *

[41] Q. Now, had you had any conversation with Dr. Reisinger through the years as to the condition that you had? A. Well, in June of 1958, when I saw I wasn't getting along very well, I had said to him: "Maybe this isn't in your field. Maybe it would be better if I went to a specialist or an internist." I was trying to find out what it was.

Q. What did he say when you mentioned that to him? A. He said: "I am an internist."

* * *

[43] Q. Now, did Dr. Reisinger, during this period prescribe any medicine for you? A. He prescribed medicines mostly for colds and respiratory infections. I think he gave me something a couple of times for heart.

Q. Now, did you take all of the medicine he prescribed for you from 1952 up through 1958? A. Yes, I did. I took it.

* * *

[47] Q. Now,then, were there any other physical examinations that he (meaning Dr. Reisinger) gave you between '54 and 1958? A. Yes. I was sent to Emergency for an X-ray. That was in 1956, I think. I was in the hospital for three days somewhere along, I think, in '56. He sent me to Dr. Kelso's laboratory for urinalysis one time, for blood test another time, for test for -- is it mononucleosis?

* * *

[63] Q. Did there come a time when you put in a claim for Workmen's Compensation? A. Yes.

* * *

[64] Q. And there was a hearing held on it? A. Yes, in March o f 1961.

Q. Now, did you ask Dr. Reisinger to testify at that hearing? A. Yes.

* * *

[65] Q. Did he say anything about a hypothyroid condition? A. Yes, he did.

Q. And what did he say? A. He said: We have suspected as far back as 1954.

Q. And that was the first time you had learned of that? A. Yes, it was.

Q. When you put in a claim with the Workmen's Compensation, do you know what your claim was? A. Yes.

Q. What was it? A. I worked in this office that was cold and [66] drafty, and I got pneumonia, and I thought the working conditions had caused the pneumonia. It was an old garage-type building. I was the only woman working there. And I thought that the pneumonia was caused by the working conditions. And I thought at that time that the myxedema was caused -- was just a follow up of the pneumonia.

Q. And that was the first time that you learned that it was suspected in 1954? A. It was the first time.

Q. And you will have this condition the rest of your life, do you say? A. That is what I am told.

* * *

[96] CROSS EXAMINATION

Q. Well, if you wanted Dr. Reisinger to do something, why did you suggest to Reisinger that you maybe ought to see another physician because what was wrong with you was outside Dr. Reisinger's field? A. I thought maybe he would want me to see somebody else. Sometimes people do consult others.

* * *

[97] Q. And that is the fact that in June of 1958, you felt some doubt that Dr. Reisinger was getting the right diagnosis? A. I felt that I was not getting the right -- any diagnosis.

Q. In June you felt that Dr. Reisinger was not getting the right diagnosis and you doubted that he was going to? A. I don't know whether I felt doubt. I felt that I wanted to get better. I wanted to get better, whether he did or somebody else helped me to get better.

* * *

[114] DR. REISINGER

* * *

DIRECT EXAMINATION

Q. How long have you been a physician? A. Since 1926.

Q. Do you have a specialty? A. Yes.

[115] Q. What is your specialty? A. Cardiology.

Q. Are you an internist? A. Yes.

Q. What books do you have in your library relating to endocrinology? A. I don't have any books in my library relating to endocrinology.

* * *

[116] Q. Is endocrinology a part of the practice of an internist? A. It is a sub specialty of internal medicine, yes, sir.

* * *

[117] Q. When did you teach medicine? A. In 1930 to 1936 I was an instructor at the University of Pennsylvania, pharmacology and internal medicine. I taught at Georgetown University in about 1939; prior to the war.

Q. Now do you keep up on current medical proceedings? A. I try to, yes.

* * *

[119] Q. Now, when Miss Baerman first came to you -- do you recall when she first came to you? A. I have the records, that is all.

Q. Did you reach a diagnosis? A. Reached the diagnosis, yes, in part.

Q. In part. What do you mean by in part? A. Well, we knew that her problem was that she had a cardiac problem incident to ligation of - incident to a long-standing patent ductus arteriosic and subsequent ligation which had imposed certain burdens upon the heart.

Q. Now, then, what is the date that you made that diagnosis? A. February 27, 1952.

Q. What is a diagnosis, Doctor? A. When are you talking about?

[120] Q. Well, a diagnosis in medicine -- you read on a medical report, "Diagnosis." What does that mean? A. That means the nomenclature that is used to express a condition that exists.

Q. So it is the art of determining the nature of a disease. A. There is a certain amount of art and experience in it, yes.

Q. What is a clinical diagnosis? A. Well, a clinical diagnosis is one that depends upon clinical findings as distinguished from laboratory findings.

Q. And clinical findings, are those the symptoms that are related to you by the patient? A. Those are the subjective findings but the objective findings are those that you find by listening, observing and palpitation.

* * *

[121] Q. Did you see her after she originally came to you in 1952? A. Yes.

Q. How long did you see her? A. Well, the last time I saw her was in 1960, January 15.

* * *

[125] Q. Now then, on your notes here in February, 1952, you state here:

"Does not look anemic. Try more rest." Was that your finding at that time? A. You are reading part of it. I said: "Does not look anemic but get count."

Q. You mean blood count? A. Yes. That is right.

Q. Now, why would you get a blood count at that time? A. Because she looked anemic and she was complaining.

Q. And you wanted to make sure whether she did or did not have it, is that correct? A. That is right.

Q. So what did you do? A. I had a blood count done.

Q. Where? A. That was at Kelso Laboratories.

Q. What date, do you recall? Do you have the record there? A. 3-14-52.

[126] Q. Now, do you call that a laboratory diagnosis? A. That is a diagnosis depending upon a laboratory finding, yes, sir.

Q. And you use a laboratory diagnosis as an aid when you, yourself, cannot determine what the condition is by looking at the patient, is that correct? A. That is correct. We use it as an adjunct or help.

Q. And that is the accepted practice in the District of Columbia is it not? A. Yes.

Q. Now, did you ever use a laboratory test to determine whether Miss Baerman had myxedema? A. I never did, no. I had Dr. Alpert do it.

Q. When did you have Dr. Alpert do it? A. He did it in September 22, started the examination September 22, 1958.

Q. And that was the first time you knew that she had myxedema? A. The first time I had laboratory evidence of it, yes, sir.

Q. Did you have any other evidence prior to 1958? A. We had clinical evidence or clincial suggestion that she probably had some impairment of her thyroid function, yes.

* * *

[127] Q. Will you look at your records there on February 1st, 1954? A. Yes.

* * *

[130] Q. What did you treat her for on that date? Did you pre-

scribe any drugs? A. I gave her iron preparation and an antihistamine preparation, Coricidin.

* * *

[131] A. No, sir, Fergon.

Q. Fergon, what is that? A. That is an iron preparation.

Q. Is that for anemia? A. Yes.

Q. And now thyroid extract, what is that for? A. That is to supplement the thyroid secretion of the body.

* * *

[132] Q. And if it is not producing a sufficient amount, what is the reaction or what is the result on the patient? A. Well, there are various degrees of involvement with lack of secretion of the thyroid. The patient may or may not have any very definite symptoms. Fatigability, drowsiness, sluggishness mentally are probably some of the early symptoms.

Q. So at that time then in February of 1954, you suspected that her thyroid gland was not performing its proper function, did you not? A. I thought that that -- some of her symptoms might be due to that. In addition to her fatigability, she was also having quite a bit of menstrual disorder, irregularity, which is sometimes a result of inadequate thyroid or too much thyroid.

Q. So at that time, then, the physical symptoms which she related to you indicated a possible loss of thyroid function? [133] A. Right.

Q. Now, at that time did you send her to a laboratory? A. For what?

Q. For anything. A. I don't remember that I did.

Q. Doctor, before you could treat a thyroid condition or a thyroid deficiency, as you called it, you would have to make a diagnosis whether she did or did not have it? A. No, that is not always essential.

* * *

Q. What do you mean? A. Sometimes you can't make the diagnosis in the early stages.

Q. Well, what methods of diagnosis do doctors use?

MR. MURPHY: For what?

MR. SPRIGGS: For making a diagnosis of the thyroid.

THE WITNESS: Well, part of it is -- part of it is the clinical examination, the condition of the skin, the history *** [134] at that time the only laboratory test that was available would have been basal metabolism.

Q. Did you send her for a basal metabolism test? A. No.

Q. You did not? A. No.

Q. And still at that time that was the one exclusive test you used to diagnose a deficient thyroid function, is that correct? A. That is not. As I have said, the clinical findings and the history are equally important because the basal metabolism is not a dependable test.

Q. So it is used then in connection with your physical clinical examination? A. That is right.

* * *

[142] Q. Now then you examined her again in March of 1954, didn't you? A. Yes, sir.

* * *

[145] Q. Now, you didn't treat her, then, for a heart condition during this period, is that right? A. Her heart did not require any treatment.

Q. The heart did not require any treatment, then, from 1952 to 1960, is that right? A. That is right.

Q. So you weren't treating her, then for a heart condition? A. I wasn't offering any treatment. I was observing her for possible changes in her heart that might require treatment.

* * *

[151] Q. Now, if you were treating the same symptoms for a period of two years, wouldn't good medical practice in the District of

Columbia indicate you should send her to another doctor? A. No. I see patients every day who have chronic heart disease,who have the same symptoms and have had for many years and will continue to have the same symptoms but they can't be improved by seeing somebody else.

Q. You said you didn't treat her for a heart condition. A. I said it didn't need treatment.

* * *

[152] Q. The only thing that needed treatment, then, was the condition of the thyroid deficiency? A. Well, she had other treatment besides that, as we have already outlined.

Q. You treated her for anemia? A. That is right.

Q. And she responded to that did she not? A. After she had also been treated for her pelvic condition.

* * *

[153] Q. Did you in the Workmen's Compensation hearing testify? A. Yes, sir.

Q. And did you state at the Workmen's Compensation hearing that you first suspected she had hypothyroidism in 1954? A. Well, I can't remember it.

Q. I ask you if you recall -- and I am specifically identifying page 42 of your testimony before the Workmen's Compensation Commission, which was taken on March 10, 1961 - ***

[154] A. "I don't think I stated it today but we have as far back as 1954 I suspected she had hypothyroidism because of her ***"

Q. But you suspected it in 1954? A. That is what it said, yes, sir.

Q. And yet you did not send her to any laboratory to find out whether she did or did not have it? A. No.

Q. And you, a practitioner, a doctor in practice in the District of Columbia cannot treat a disease until he knows what it is, can he? A. Sometimes we have to treat it whether we know what it is or not.

Q. What do you mean by that? A. I mean you can't always know what is the cause of certain symptoms and we have to treat the symptoms.

Q. But if you can know, you find out, do you not? [155] A. That is right.

* * *

[156] Q. Now, doctor, is there a difference between hypothyroidism and myxedema? A. No, they both refer to hypothyroidism.

Q. Is it or is it not? A. I think myxedema is a term that is often used for the more severe grade of hypothyroidism, but there are many degrees of thyroid insufficiency.

* * *

[159] Q. Myxedema, then, is curable? A. I would qualify that. I would say that the condition can be relieved by supplying the thyroid substance exogenously rather than from the thyroid gland, itself.

* * *

[164] SAUL W. ROSEN, M.D.

* * *

Q. What is your name? A. Saul Rosen.

Q. Where do you practice? A. I do clinical investigation at the National Institute of Health.

Q. Now did there come a time when you examined a Miss Katharine Baerman? A. I first saw Miss Baerman in 1959 in August.

[165] Q. And where? A. In the clinical center of National Institute of Health.

* * *

[167] Q. Now, did the hospital prescribe a course of treatment while she was in the hospital? A. Well, we attempted to assess objectively her thyroid function, which we then did, and she was found to be hypothyroid, as she had been found before.

* * *

[168] Q. Now then, when you say there that physical objective

tests were given -- Objective tests, what are they? A. Well, that is laboratory. An objective test is one which didn't require subjective interpretation on the part of the physician.

A physical examination or many parts of it would be a subjective test. An objective test would be laboratory determination, blood test, examining circulating thyroid, hormone, X-ray determination of how much radioactive iodine up-take in the area of a person's thyroid gland, and so forth. These are objective tests.

Q. What is the purpose of objective tests? A. To eliminate subjective error as far as possible.

[169] Q. I see, and that is what the hospital gave her? A. Well, we did other things as well. We took a history and did a physical and did laboratory examinations, the usual complete work-up.

* * *

[174] A. Hypothyroidism is an ancient disease.

Q. There are certain tests that can rule it out? A. There are tests of thyroid function. There are a lot of tests of thyroid function.

Q. How many tests are there? A. I can't give you a number. There are different tests that measure different things. The test I was discussing before measures the ability of the thyroid gland to attract radioactive iodine. The blood test measures circulating thyroid hormone. Metabolic rate measures the response of tissues to the thyroid hormone.

Q. They are all laboratory procedures, are they not? [175] A. Yes.

* * *

[177] Q. Is myxedema curable? A. Depends on how you define curable. It is treatable.

Q. Then under the circumstances it would be important [178] to catch the condition as soon as possible? A. Well, I guess it is desirable to catch every condition as soon as possible.

* * *

RICHARD E. KELSO

* * *

[186] Q. In connection with your medical practice, do you have any other occupation or do specialize in any specific thing? A. Yes, my field is pathology.

Q. And what do you mean by pathology? A. Well, pathology is a branch of medicine which is the study of the causation of disease, the examination of various body tissue and analysis of same in determining the causation of disease.

Q. Now, the causation of disease -- that is one of the main function of the practice of medicine, is it not? A. Yes, sir.

[187] Q. Now, the study of the causes of diseases, that relates to a diagnosis, does it not? A. I think it relates to diagnosis, yes, sir.

* * *

[188] Q. I see, Doctor, you say you receive requests from other doctors to diagnose a disease? A. Well, not necessarily diagnosis. The tests are sent to them to aid them in diagnosis.

In other words, if a patient comes in to the doctor and he feels she may be anemic, he sends the patient over for a blood count. We then report what we find in the analysis and send a report back to him, with normal findings in report form, [189] and he examines the reports and he interprets the reports. *** If he has questions about this particular smear or something, then he will call me or call the pathologist and ask what he thinks about it.

In general, our work is pretty objective. We do the analysis and submit a report to the referring physician and he interprets it.

Q. When you say objective, you mean that you perform laboratory tests? A. Right.

Q. Doctor, you say you perform laboratory tests. A. Yes, sir.

Q. And the laboratory test is for what purpose? A. Well, laboratory tests are basically for three things: One is for aiding in diagno-

sis; two, in the treatment of the patient; [190] and number three, prognosis as to how the patient may progress in his or her illness.

* * *

[191] Q. Now, in your laboratory tests during 1954 and 1958, did you ever have facilities to determine -- to perform an examination to determine whether a patient had a hypothyroid condition? A. We had tests at that time; we have tests at present for the purpose of determining metabolic function, thyroid disorders, yes.

Q. What is a metabolic function of the thyroid? A. Well, essentially, it is the activity of the thyroid gland which is a prime organ for regulating the oxygenation process of the body. In other words, as food is ingested, and all the other body functions, why, the thyroid is the prime gland, so to speak, which produces the enzymes and hormones that causes these oxygenating processes to occur.

Q. It is one of the important glands, then, of the body, is it not? A. It is, sir, yes, sir.

* * *

[192] Q. Can you give us the tests that you used to determine a patient's condition for hypothyroidism? A. Well, the tests that we were using at that time and at the present time are the basal metabolism test, the protein-bound iodine test, usually referred to as the PBI.

* * *

[193] Q. Now, this protein-bound iodine, that was in existence at that time? That was used -- when was that used, what year, do you recall? A. Well, the first work, as I recall, came out about 1951 but it wasn't universally used until about 1953 or 1954.

* * *

[194] Q. Now, the machinery you used, then was the basal metabolism test? A. Yes, sir.

Q. How long has that been in use? A. I can't tell you exactly -- but I would say probably since perhaps 1920, maybe even perhaps earlier than that. This is basic procedure.

Q. That was then one of the specific tests that had been in use by the medical profession to determine or to assist them in determining the findings of the thyroid gland; isn't that correct? A. It is, I would say, one of the laboratory procedures that was used primarily for this work, yes.

* * *

[195] Q. And it was used in conjunction with the clinical findings that the doctor, himself, took from the patient, isn't that correct? A. Well, I would say it was just one more procedure which a doctor used to aid him in his diagnosis, yes.

* * *

[202] DOCTOR LEWIS P. LEVITT

* * *

[203] Q. Now, what type of practice do you have at the present time? A. General practice.

Q. Now, in your practice of medicine, have you ever had an opportunity to treat people with a hypothyroid condition? A. Yes.

Q. Now, Doctor, in the practice of medicine, what is the most important function of a doctor in treatinga patient? A. Well, first, to establish a diagnosis by proper [204] physical examination, and then prescribe proper medications for the individual.

Q. The most most important function, then, of a doctor, is to diagnose an illness, is that correct? A. In order to treat the case properly.

Q. And it is important to make a diagnosis at the start of your treatment? A. Before treatment is begun.

Q. And what is the reason for that? A. So that the proper medication might be prescribed for the sickness that the individual has.

Q. In other words, you cannot treat a patient until you know what is the matter with him, is that correct? A. We establish the diagnosis first.

Q. Now, relating to hypothyroidism, is there any specific diagnosis that you use to determine whether a patient does or does not have it? A. Well, there are two methods of approach. One is the physical examination and the signs and symptoms the patient presents; and secondly, any other laboratory procedures which may benefit the doctor in prescribing for the patient.

Q. Now then, the physical or clinical findings, what do they consist of? [205] A. Well, a low blood pressure and dry scalp and falling of the hair and a swelling of the skin of the face, etc.

Q. Now, if you have the physical symptoms which you mentioned and you suspect a deficiency in the thyroid function, what is the next step a doctor must do to treat his patient? A. Well --

MR. MURPHY: I object. It is not a proper hypothetical question.

THE COURT: I will sustain the objection.

Q. Well now, Doctor, do you in your practice use the laboratory to assist you in your diagnosis?

MR. MURPHY: I object. That is not an issue in this case.

THE COURT: Yes, I will sustain the objection to that question.

* * *

[206] Bench Conference

THE COURT: I don't think whether this doctor uses the laboratory test is the issue in this case. But I am concerned about your question before that. I think that you can phrase a hypothetical question which will be sufficiently comprehensive to elicit from the doctor what is the accepted practice in the community under similar circumstances, it would seem to me. Don't you think he can do that.

MR. MURPHY: I think he can. I would like on the record to make an objection to this doctor giving an opinion as to what a cardiologist would do in a situation. I don't think he is competent to testify. I realize this is within the discretion of the Court as to whether he can or not.

THE COURT: Well, I think if you properly phrase your question, you can elicit from him what is the practice in the community among experts in this particular field.

No, I don't think you can because he is not an expert in the field.***

* * *

[208] THE COURT: I will sustain the objection.

Q. When did you examine Miss Baerman? A. I examined her on May 10, 1961.

Q. What did you examine her for? A. Well, general physical examination.

Q. And did you make a diagnosis? [209] A. Yes. I thought that she had at the time an under functioning thyroid gland.

Q. Now, Doctor, you have treated other patients with a hypothyroid condition in your practice? A. Yes.

Q. And would you say you have treated many? A. Well, I would say an average number that a doctor uses.

* * *

[211] Q. Now, Doctor, in your practice, let us assume that a patient, 55 years of age, comes into your office in 1952, gives you a history at that time that she had had an operation on the heart in San Francisco in 1948, and she came into your office in February, 1952 and gave you that history, and she continued to come to your office each year several times a year from 1952 to 1958, that the main symptoms which she had were: I am tried; there is a difficulty with the menstrual function; and the main symptom is fatigability and menstrual irregularities.

You treat her for anemia; and you, in 1954, suspect that she has a condition of deficiency in the thyroid gland. You base that upon the clinical or history as related to you by the patient, [212] but you at that time, when you suspect the hypothyroid condition, do not send her to a laboratory to find out whether she did or did not have that condition. And you continue to treat her for anemia and respiratory infections.

Do you have an opinion with any reasonable degree of medical certainty whether that would be accepted practice in the District of Columbia?

MR. MURPHY: I object, Your Honor.

THE COURT: Objection sustained.

Q. Now, Doctor, in your practice, in reaching a medical diagnosis, do you use the laboratory as an aid to determine the condition of hypothyroidism?

MR. MURPHY: Objection.

THE COURT: Objection sustained.

Proffer Made at Bench.

MR. SPRIGGS: I make the proffer of these questions to prove that the established practice in the District of Columbia, when a person suspects hypothyroid condition, [213] is to send the patient to a laboratory, and that the failure to do so is not the accepted practice in the District of Columbia.

THE COURT: What do you say?

MR. MURPHY: I object, Your Honor, on the ground, first, I don't believe this doctor could testify as to what the defendant doctor ought to have done, which is the issue in this case.

I don't believe that the question contains nearly all of the facts which were presented to the attending physician and which should be contained in the question. And there was an assumption in the question which is not in evidence, that the test will show what the condition is.

All of the testimony presented by Mr. Spriggs, is that the test is unreliable and that the doctor's findings are by far more reliable than what you can get after the basal metabolism test.

MR. SPRIGGS: The testimony of Dr. Rosen yesterday was that the purpose of using the laboratory was to check and avoid the possibility of error in a clinical diagnosis.

THE COURT: I will sustain the objection.

[214] Q. Doctor, is it accepted practice in the medical profession in the District of Columbia to fail to treat a specific illness for a period of 4 years?

MR. MURPHY: Objection.

THE COURT: Objection sustained.

Q. Is it accepted practice in the medical profession in the District of Columbia to use the laboratory to assist the practicing physician in reaching a final diagnosis?

MR. MURPHY: I object.

THE COURT: Objection sustained.

Q. Is it accepted practice in the District of Columbia for a doctor treating a patient to make a diagnosis before embarking upon a treatment for any illness?

MR. MURPHY: I object.

THE COURT: Objection sustained.

Q. Is it accepted practice in the District of Columbia for a practicing doctor to apply all of his medical knowledge to a patient's physical complaints constructively in the interest of the recovery of the patient?

[215] MR. MURPHY: I object, your Honor.

THE COURT: Objection sustained.

Q. Would it be accepted practice in the District of Columbia for a medical practitioner to fail to use his knowledge, medical knowledge constructively in the interest of his patient?

MR. MURPHY: I object.

THE COURT: Objection sustained.

Q. Is it accepted practice in the District of Columbia for a doctor to carry a study of a patient's illness far enough to make a positive diagnosis of the ailment?

MR. MURPHY: I object.

THE COURT: Objection sustained.

Q. Is it accepted practice for a medical practitioner in the Dis-

trict of Columbia to guess at a disease when you can know by use of the laboratory?

[216] MR. MURPHY: I object.

THE COURT: Objection sustained.

Q. Doctor, if a patient has an underactive thyroid, does the deficient hormone slow down the heart by causing various changes in the heart muscle? A. The heart action is lowered and the pulse rate is lessened.

Q. And is a patient with a hypothyroid condition susceptible to respiratory infections? A. Yes.

Q. If a patient is put on a treatment for a thyroid deficiency early, would there be a better chance for a complete recovery? A. The treatment is to be started as quickly as possible after a diagnosis is established.

Q. And what is the purpose of that? [217] A. Just to assist the functioning of the thyroid gland, one, and secondly, the endocrine chain of organs in the body --

THE COURT: Did you say you treated her?

THE WITNESS: I saw her on one occasion, made a physical examination of her.

Q. Did you make a diagnosis? A. Yes.

* * *

[220] Q. Does a deficiency in the thyroid gland harm the patient? A. Yes.

* * *

[222] DR. LOUIS K. ALPERT

* * *

Q. Do you practice a particular specialty? A. Internal medicine.

* * *

[223] Q. Doctor, assuming that a patient came to your office in 1952 with a history of having a heart operation, a ligation of the patent ductus arteriocosis in 1948, and she comes to your office on February

27, 1952, and she informs you that she feels full in the chest, not actual pain, has had pain, and that there was no dyspnea; and you at that time gave a complete physical examination, physical and fluorscopic, and you made the note that she does not look anemic but get a blood count; you advised her to try to get more rest; and that she [224] came to see you on March 17, 1952 complaining of pain in the chest and in a tooth; and you gave her empirim, B-12, and some Histamine; and she came to you again March 27, 1952 complaining that she hurts in the upper left chest, was tired all through the chest, sleeps restlessly; and you observed no dyspnea; and she came to you again complaining of fatigue; and she came to you in June of 1952, fatigues more readily, lacks muscular energy, couldn't lift two year old child, can't hold herself up when she is tired; and you observed that the chest was clear, no edema; *** and you noted on your record that in 1954 you suspected a condition of hypothyroidism; you had taken no laboratory examination to determine whether the patient did or did not have a condition of hypothyroidism.

Would you have an opinion as to whether a doctor, who made a tentative diagnosis for hypothyroidism, yet used [225] no laboratory examinations to determine whether he was right or wrong, but still treated the patient for four years without a laboratory examination -- do you have an opinion which you can express with any degree of reasonable medical certainty whether that would be negligence or not on the part of that doctor?

MR. MURPHY: I object. ***

* * *

[229] Q. Doctor, assuming the facts I have told you, do you have an opinion, based upon any degree of reasonable medical certainty as to whether or not it is accepted practice in the District of Columbia to continue to treat a patient that you suspect has a hypothyroid condition without first using the techniques of the clinical laboratory to form a diagnosis? A. Well, the question which you have stated is a very complicated one. Not only in terms of the time which it covers, but you

are really in a sense [230] asking me for an opinion about something which I have not seen personally. That is, I haven't seen this patient.

With regard to what might be considered accepted practice -- and again, this is somewhat a matter of understanding -- I will try the best I can to answer your question. I am not sure whether I can do it satisfactory -- First of all, I may have missed this fact, but when you say the patient was treated, I am not quite sure what type of treatment she received. You may have stated it but I just didn't catch it. Could you tell me what that was?

MR. SPRIGGS: In 1954 when they first suspected it, the doctor treated her with B-12-Tregon, thyroid and Coricidin.

[231] THE WITNESS: I would say that if the clinical suspicion or clinical impression of the doctor, that is, his impression about the status of the thyroid is on his examination is strong enough that the patient has hypothyroidism, I would say that most of the time he would have a laboratory test done unless there were certain factors which would contra-indicate it or would perhaps make it unnecessary. ***

[232] I think that the clinical impression of a well qualified physician is very important and can sometimes outweigh the laboratory results.

Q. Would you say, then, when a doctor makes a diagnosis that a patient has a hypothyroid condition, it becomes incumbent upon that doctor to take all steps available to treat that patient? Is that right? A. If he has a high degree of assurance in the sum total of his own opinion about the condition of the patient, that is, in reference to that particular element, I would say yes. If there are no other factors which conceivably might mitigate against administration of thyroid.

A competent physician must consider not only the one system that he is looking at, the thyroid in this instance, but other factors in the patient, too.

I am not sure whether I have answered your question.

Q. But the basic tenent of the question was that if a doctor makes a diagnosis of a hypothyroid condition, it becomes incumbent upon that doctor to treat it? A. Usually, yes.

* * *

[235] Q. Doctor, what is the purpose of a laboratory examination? [236] A. To clarify or confirm a clinical impression with regard to the diagnosis.

Q. And a clinical impression is based solely upon the symptoms as related to you by the patient? A. No, I would include the physical examination.

Q. Is that what you mean when you say clinical examination? A. Yes.

Q. You use the laboratory, then, to determine your diagnosis which you found clinically? A. To confirm it.

[237] Yes, I personally,never use the laboratory alone to make a diagnosis. I think it is not proper. I think it should be used for the confirmation of a clinical impression.

* * *

[239] Q. But in this case you mentioned in your notes that your laboratory examination confirmed the diagnosis of hypothyroidism. A. That is correct.

Q. Therefore it is right? A. Yes, it confirms my clinical impression.

* * *

[255] VINCENT PAUL SWEENEY

* * *

Q. Do you have a specialty? A. Internal medicine.

* * *

[260] Q. How do you determine whether a patient has hypothyroidism? A. Well, there are several ways of doing it. First of all, clinically, by history, and the physical examination of the patient, and

secondly, by laboratory tests, appropriate laboratory tests which are available at this time.

Q. What was that? A. The appropriate laboratory testing of the function of the thyroid gland.

Q. You utilize both in making a diagnosis? [261] A. I would utilize the thyroid function test to confirm the clinical impression that a patient was not adequately producing her own thyroid. It is a test I would use to confirm any clinical impression.

Q. After you confirmed it, what would you do? A. Appropriately treat the patient.

* * *

[265] Q. Now, if there were a deficiency in the thyroid function, is it important to determine that and to put the patient on treatment as soon as possible? A. Yes, depending -- you have to take the whole patient into consideration. There are many people who are deficient in thyroid and for whom it is maybe in their best interest that it is not completely replaced. ***

Apart from examples like that, it would be desirable to replace the deficiency that the patient had.

Q. That would be the ordinary practice in the District of Columbia? A. Yes, it would.

APPELLEE'S BRIEF AND APPENDIX

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 19,643

KATHARINE BAERMAN, *Appellant*,

v.

JOHN ALFRED REISINGER, M.D., *Appellee*.

Appeal From the United States District Court for the District of Columbia

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QUESTION PRESENTED

Whether the trial Court properly directed a verdict at the close of the plaintiff's evidence in a professional malpractice case, the plaintiff having failed to offer any evidence of the standard of practice for like practitioners, and consequently no departure therefrom by the defendant; and the plaintiff also having failed to offer any proof that in fact the plaintiff was suffering from hypothyroidism in February of 1954 when the plaintiff contended that the defendant should have made a diagnosis of hypothyroidism.

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United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 19,643

KATHARINE BAERMAN, *Appellant,*

v.

JOHN ALFRED REISINGER, M.D., *Appellee.*

Appeal From the United States District Court for the District of Columbia

---

BRIEF FOR APPELLEE

STATEMENT OF FACTS

The Appellee is a physician practicing in the District of Columbia since 1926 and specializing in internal medicine and primarily in the specialty thereof described as cardiology. (App. p. 8). The Appellant first became a patient of the Appellee on February 27, 1952 at which time by history and examination the Appellee diagnosed that the Appellant had a cardiac problem incident to the ligation of a long standing birth defect in the heart. (App. p. 10). The

Appellant's heart was fluoroscoped revealing an enlarged heart. Thereafter on March 14, 1952 the Appellant made a diagnosis of anemia. (App. p. 10).

Thereafter on February 1, 1954 the Appellant complained to the Appellee of pain in her lower abdomen, vaginal bleeding for over one week's duration with some clotting, pain in her left upper chest but no pain on breathing or shortness of breath. The physical examination at that time indicated a blood pressure 150/90, a heart rate of 80 with a regular rhythm and an enlarged heart with a harsh cystolic murmur at the base especially on the left side. (App. p. 12). The Appellant was on this date suffering from one of the numerous colds which she had during the course of her relationship with the Appellee. (App. pp. 12, 13). The Appellee at this time also prescribed a short therapeutic dosage of thyroid extracts as he thought some of her symptoms might be due to a malfunction of the thyroid. The doctor testified that he could not make a diagnosis of thyroid malfunction at that stage. (App. pp. 13, 14). The Appellee referred the Appellant to a gynocologist and himself continued to follow the heart, the anemia and the numerous respiratory infections, the latter of which complaints resulted primarily from a defect in her pulmonary circulation secondary to the heart condition. (App. p. 19). The Appellee was asked, and he was the only witness who was asked, whether the Appellant had normal thyroid secretion in 1954 and he stated that he did not know. (App. p. 24).

In February of 1958 the Appellant had an atypical pneumonia and was hospitalized by the Appellee for eleven days. In 1958 the Appellant developed a great many symptoms that were to her "*unusual* and frightening". She was then suffering from pain in her throat, difficulty in speaking, difficulty in locomotion, a wooden feeling in her legs, swelling in her face, arms and abdomen. (App. p. 27). These symptoms developed between March and June of 1958 at the time that the Appellant consulted a Dr. G. Haven Mankin,

an ear, nose and throat specialist to whom the Appellant gave the symptoms of a sore and painful throat, difficulty in speaking, hoarseness. (App. pp. 4 and 5). In the summer of 1958 the Appellee referred the Appellant to Dr. Lewis Alpert an Endocrinologist who performed an examination and did a radioactive iodine test and made a diagnosis of hypothyroidism. This diagnosis by Dr. Alpert was made in September of 1958. The Appellant was started on a course of thyroid extract.

Thereafter Appellant in approximately November of 1958 visited her home in Minnesota where she was examined by a Dr. Ulrich to whom she related the symptoms that she had in June of 1958, and at the time she was examined by Dr. Alpert, and Dr. Ulrich did two basal metabolism tests which were unsatisfactory and Dr. Ulrich informed the Appellant that he did not think she had hypothyroidism, and took her off the medicine. (App. p. 7).

The Appellant returned to Washington, D. C. in the Spring of 1959 at which time she was again diagnosed to be hypothyroid which diagnosis was made again by the use of the radioactive iodine up-take test (Tr. 52-53).

The Appellant had some difficulty in accommodating to the medicine and was studied at the National Institutes of Health where a complete work-up again indicated the Appellant to be hypothyroid although again basal metabolism test was an unreliable test but was the standard test until approximately 1955. (App. p. 28).

STATEMENT OF POINTS

I.

The full transcript of the testimony of Lewis P. Levitt, M.D. will indicate that it is unclear at best whether the trial Court ruled that any specific question could not be asked based upon a finding of the witness' lack of competency. All of the questions asked of Dr. Levitt to which an objec-

tion was made and sustained were objectionable on more grounds than the qualifications of Dr. Levitt.

II.

The qualifications of an expert witness rest within the sound discretion of the trial Court.

III.

The Appellant failed to offer any proof that the Appellant was in fact suffering from hypothyroidism at any time prior to June 1958 at which time the Appellee diagnosed the disease.

IV.

The Appellant offered no proof of a standard of medical practice in the circumstances alleged by the Appellant and therefore, of course, offered no proof of a departure from that standard.

SUMMARY OF ARGUMENT

The Appellant presented herself to the Appellee with a history of a congenital heart defect which had been operated on and thereafter over the period 1952 to 1958 presented symptoms of various degrees of fatigue, anemia, female difficulties, respiratory infections and finally a pneumonia followed by the development of symptoms diagnosed as hypothyroidism.

In February of 1954 the Appellee had a suspicion that the Appellant might have a deficiency in thyroid function but the symptoms were not clear enough to make a diagnosis on the clinical findings which included fatigue which would have been related to the anemia and menstrual difficulties which might possibly have had a relationship to thyroid function but which cleared up after treatment by a gynecologist.

The symptoms of hypothyroidism, i.e. dry skin, weight gain, fatigue, mental slowness and swelling and hoarseness of the voice, did not develop until at least March of 1958, by the testimony of both the Appellant and Appellee.

No physician testified that on the symptoms presented to the Appellee in February of 1954 that he should have made a diagnosis of hypothyroidism or that he should have done anything other than what he did do in his care of the Appellant. The Pre-trial Order in this case charged the Appellee with failure to diagnose the condition in 1954, however, no evidence was offered that the Appellant did in fact have hypothyroidism in 1954.

The Appellant did in many instances attempt to ask physicians, especially Dr. Levitt, what they personally would do in a situation. This was of course objected to and sustained as irrelevant to the issue of whether what the defendant did was within the accepted standards of practice.

The Appellant having offered no competent evidence with regard to the accepted standard of practice and whether the behavior of the defendant was a departure therefrom the trial Court was required to and properly did direct a verdict in favor of the Appellee.

ARGUMENT

I.

A Complete Reading of the Transcript of Dr. Levitt's Testimony Will Indicate That Although the Trial Court Did Express Doubt as to the Competency of Dr. Levitt to Testify as to the Standard of Practice of Cardiologists. Dr. Levitt Was Allowed to Testify to Many Expert Opinions, and Those Questions to Which Objections Were Sustained Were Sustainable on Grounds Other Than the Lack of Competency on the Part of Dr. Levitt.

Dr. Levitt was asked (App. pp. 32, 33) what the physical or clinical findings of a hypothyroid patient are and he testified a low blood pressure, a dry scalp, falling of the hair,

a swelling of the skin and face, thickness of the tongue, apathy and a tendency of drowsiness and lack of vitality. Then Dr. Levitt was asked "Now, if you have the physical symptoms which you mentioned and you suspect a deficiency in the thyroid function, what is the next step a doctor must do to treat his patient". This question was objected to as incomplete and sustained. Then Dr. Levitt was asked "Well now, Doctor, do you in your practice use the laboratory to assist you in your diagnosis". This was also objected to and counsel were asked to approach the bench. The Court then informed counsel for the plaintiff that he did not feel that what the witness did was relevant to the case but that he felt Appellant's counsel could frame a sufficiently complete and proper hypothetical question to elicit what were the accepted standards in the community under similar circumstances to those which presented themselves to Appellee. Appellee's counsel agreed that such a question could be formed based on the evidence then in the record but stated that an objection was still maintained as to the witness' qualifications to express an opinion as to what a cardiologist should have done in the situation. The Court then expressed some doubt as to the witness' competency on such a question and then Appellant's counsel stated to the Court (App. p. 34) "Yes, but he doesn't have to be an expert to treat hypothyroidism. He has treated hypothyroid conditions himself in his private practice and he has so stated. He can certainly testify as to what the practice is, what he does." The Court then stated, "I don't think so. I don't think what he does is really in this case at all, what an individual doctor does". Thereafter there was further colloquy on the dual question of the witness' competency and the relevancy of his testimony regarding his personal practice. Finally the Court sustained the objection.

The witness expressed further general opinions with regard to hypothyroidism and then again was asked a

further hypothetical question. (App. p. 35). Objection was made to this question on several grounds, one of which was the competency of the witness to express an opinion with regard to the practice of the Appellee. The Court sustained the objection and did not specify the ground for sustaining the objection nor was the Court asked so to do.

The Appellant here complains also of a long series of questions which were asked of Dr. Levitt all of which were sustained. This series of questions is set forth in the Appellant's Appendix at pages 26 and 27. A reading of these questions will more eloquently justify the Court's sustaining of the objections thereto than any argument which could be made about them.

The rule with regard to the qualification of expert witnesses has long been set out in this jurisdiction and has been carried through several decisions of this Court. The rule was first set forth in the case of *Raub* v. *Carpenter*, (1901) 17 App. D.C. 505, wherein this Court stated that the determination of the trial Court as to the qualification of an expert witness should not be reversed unless the trial Court's action constituted a clear and palpable error. The determination of the qualification of an expert witness falls within the sphere of the trial Court's exercise of discretion. *District of Columbia* v. *Chessin*, (1932) 61 App. D.C. 260, 61 F2d 523, see also *Pollard* v. *Hawfield*, 83 App. D.C. 374, 170 F2d 170, certiorari denied 336 U.S. 909, 69 S. Ct. 514, Rehearing denied 336 U.S. 929, 69 S. Ct. 654; *Gertner* v. *Newrath* (D.C. Mun. App.) 49 A2d 655; *Frazer* v. *Crounse* (D.C. Mun. App. 1948) 56 A2d 54; *Davis* v. *District of Columbia* (D.C. Mun. App. 1948) 59 A2d 208.

The last occasion upon which this Court reviewed such a question is the case of *Sher* v. *Dellaven*, (1952) 91 App. D.C. 257, 199 F2d 777. This Court referred to Pollard Supra and stated,

> "Whether he is qualified to express an opinion on a particular subject is for the trial Judge, in his dis-

> cretion, to decide. Ordinarily his decision will not be disturbed on Appeal."

Therefore, it is submitted that had the trial Court specifically sustained objection to Dr. Levitt's testimony on the basis of his qualification to express an opinion as to the standard of practice among cardiologists, this determination would fall within the exercise of the trial Court's discretion; and there is nothing in the record of this case to justify a claim that the judge's discretion was palpably erroneous.

Most of the questions presented to Dr. Levitt to which objection was made asked Dr. Levitt to express what he himself would do in a particular set of circumstances. These, of course, were objected to as being irrelevant. The practice of any learned profession will obviously entail some leeway for individual conviction, judgment, experience and training. Dr. Reisinger, the Appellee, was not sued for failing to practice medicine in the manner of Dr. Levitt but because his actions were alleged to have fallen outside of the realm allowed for individual differences in the practice of the profession. Stated otherwise, Dr. Reisinger is sued for failing to adhere to acceptable standards for other practitioners of his learned profession as it would be manifestly impossible for him to practice in conformity with each individual's personal judgment and predilection. It would seem to be superfluous to have to argue such a point before a Court composed of professional persons who in the practice of their own profession have observed the individuality of technique and approach among practitioners of the profession and yet are also aware that there are certain boundaries to that individual notion of practice. However, the Supreme Court of the United States has in a recent case stated that testimony by an individual physician as to what he personally would do and what he personally thinks is proper constitutes

fatally deficient evidence in support of a claim of professional malpractice. *Davis* v. *Virginian R. Co.*, (1960) 361 U.S. 354, 80 S. Ct. 387.

II.

The Appellant Failed to Present Any Evidence That She Was in Fact Suffering From Hypothyroidism at the Times She Alleges the Appellee Negligently Failed to Diagnose the Condition.

The Appellant has accused the Appellee of professional malpractice for failing to diagnose a condition of hypothyroidism commencing in 1954 and in negligently failing to treat the condition. The Appellee testified that he made no diagnosis of hypothyroidism until June of 1958 and that he does not know whether she had hyperthyroidism in 1954.

The first logical question to be asked in such a situation is, was the physician in fact wrong which in this situation would be concretely asked by examining into the question of whether the Appellant actually had hypothyroidism at any time prior to 1958 when the classical symptoms of hypothyroidism were apparent. Nowhere in the record is there any evidence as to the specific cause of the Appellant's hypothyroidism or when it developed. Nowhere was any physician asked to state with reasonable medical certainty whether or not the Appellant was suffering from hypothyroidism in 1954 or for that matter 1955, 1956 or 1957 when the Appellant alleged the Appellee was negligent for failing to diagnose hypothyroidism. The Appellant having failed to offer any evidence on this question would require a jury to speculate as to whether in fact she had hypothyroidism and therefore whether in fact the Appellee was mistaken or not. This is an obvious logical requirement before anyone can proceed to examine into whether the Appellee, if mistaken, was mistaken because of negligence.

III.

The Appellant Failed to Offer Any Evidence of the Accepted Standards of Practice With Regard to Symptoms Related By the Appellant and, of Course, Therefore Offered No Evidence as to a Departure From That Standard.

This Court in the recent case of *Price* v. *Neyland*, (1963) 115 App. D.C. 355, 320 F2d 674 reiterated the elements of proof in a professional malpractice case citing the Supreme Court case of *Davis* v. *Virginian R. Co.*, *Supra*. The opinion of this Court stated that the plaintiff must offer testimony of the recognized standard of medical care in the community which would be exercised by physicians in the same specialty under similar circumstances and that the physician departed from that standard. The Appellant in the Brief filed in this Court apparently concedes that proof of these recognized standards and the departure therefrom was not offered in this case as the Appellant argues that no expert testimony should be required in this case. We believe that it is patent that a patient who presents a reasonably complicated medical picture such as a post-operative congenital heart defect with secondary pulminary circulatory involvement and disorders of the genital tract together with generalized symptoms of fatigue and enlargement of the heart presents a picture sufficiently complicated to require testimony from those skilled in the healing arts as to what standards of practice should be applied. *Quick* v. *Thurston*, (1961) 110 App. D.C. 169, 290 F2d 360.

Again, no physician was asked a proper question presenting the symptoms and medical history alleged to be present by the Appellant and thereafter asked whether the accepted standards of practice would lead a physician to a diagnosis of hypothyroidism. In place of framing such questions, questions of the nature which appear on pages 26 and 27 of the Appellant's Appendix were asked, and now this Court is asked to substitute for the lack of evidence a vague approval of an emotional argument that

professional malpractice is difficult to prove, as indeed it ought to be. This case presents a classic picture of the difficulties presented to a person practicing a learned profession. In the learned professions of law and medicine the basic ingredient with which the practitioner is dealing, i.e. human beings, vary as often as there are individuals. The practitioner of the law must evaluate a client's ability to tell the truth, his willingness to tell the truth, the effect of his personality in telling his version of the evidence and most importantly his ability to accurately describe or remember and to this he must add what he can physically observe of his client and evaluate what this physical observation will mean in the eyes of other persons, and lastly, he must evaluate the physical evidence which is available such as writings or pieces of materials and draw conclusions as to the effect of this evidence and the uses to which it may or should be put. Likewise our brother professionals in the healing arts must deal with variable physical specimens and the varying personality and psychology. The practitioner of the healing arts must listen to a patient describe symptoms such as fatigue which as Dr. Rossen testified is a very subjective and therefore variable symptom which must be evaluated as against the physical conditions such as edema which again Dr. Rossen testified is an objective clinical finding and after evaluating the history obtained from the patient which again is subject to the variables of the patient's conclusions and memory the physician makes a clinical diagnosis, and, as all of the physicians testified in this case, if a clinical diagnosis is made and, if a laboratory test is normally used to confirm this diagnosis, and if in the patient's individual case the laboratory test is expected to be of value, a laboratory test is taken. If the laboratory test does not conform to the clinical diagnosis, the testimony in this case, as it was in *Price Supra*, indicates that the laboratory test should be ignored or re-run. The total effective medical testimony in this case was that, if the Appellee had sufficient clinical information to make a diagnosis, then, and

only then, would a laboratory test be considered. No such diagnosis was made and therefore all of the testimony about the laboratory test is beside the point. However, it is interesting to note that at the time Dr. Reisinger had a suspicion that the Appellant might have hypothyroidism the accepted test available in the District of Columbia was the basal metabolism test which test has proved with the Appellant to be unreliable because of her nervous condition, she having had two such tests under the care of Dr. Ulrich and one at the NIH all of which indicated normal thyroid function.

The general rule with regard to the granting of a directed verdict has been enunciated in this jurisdiction in the cases of *Shewmaker* v. *Capitol Transit Co.* (1944) 79 App. D.C. 102, 143 F2d 142, *Murray* v. *Towers* (1956) 99 App. D.C. 293, 239 F2d 914 and the application of this rule to medical cases has been enunciated by the Supreme Court of the United States in the *Davis* v. *Virginian R. Co. Supra.* It is submitted that on the record the trial Court properly administered the law as between the parties.

CONCLUSION

The trial Court properly applied the law and exercised its discretion with regard to evidentiary rulings and that the Court properly applied the law to the record with regard to granting a directed verdict.

Respectfully submitted,

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APPENDIX

APPENDIX FOR APPELLEE

27 **Katherine Baerman**

was called as a witness in her own behalf and, having been first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Spriggs:

Q. What is your name? A. Katherine Baerman.

* * * * * * * * * *

34 Q. When did you first go to see Dr. Reisinger? A. February 27, 1952.

* * * * * * * * * *

35 Q. What were your complaints? A. The complaint was mainly that I was very fatigued, that I had a tiredness in sitting up and working all day, tired from my chest—general fatigue.

* * * * * * * * * *

37 Q. What were your complaints throughout all this time? A. Well, all throughout it was fatigue, exhaustion. There were many other complaints as time went on. As I said, I had this irregular menstrual trouble for which he sent me to Dr. Carlton Price; and Dr. Carlton Price said because I was losing weight so and bleeding, that he thought I might have a cancerous condition and he took a biopsy and did a minor operation.

* * * * * * * * * *

38 Q. When did you first learn that you had myxedema? A. When Dr. Louis Alpert told me at the Warwick Memorial Clinic for Cancer and Allied Diseases.

Q. And do you remember when that was? A. That was in September of 1958.

Q. Who was your doctor at that time? A. My regular doctor was Dr. Reisinger.

Q. And what was your condition when you went to Dr. Alpert? A. I had a great many symptoms that were to me unusual and frightening. I had developed—well, one of the first things was pain, pain in my throat, difficulty in speaking. First it started with no voice; I just had to force my voice. Then it got so my voice was hoarse. I sounded as if I were talking with a mouth full of mush. I had difficulty in locomotion. My legs felt wooden, as if they were not part of me. I had swelling of my face. At first it was just my face. Then it went into my arms; then went into my abdomen. Some days there would be much swelling, sometimes not much.

* * * * * * * * * *

41 The Court: I am not sure but what she can answer the first question, if she had any idea that she had it before this time. I think she may answer the question.

By Mr. Spriggs:

Q. Did you have any idea that you had this condition before Dr. Alpert told you? A. No, I didn't. I had no idea what I had.

* * * * * * * * * *

42 Q. Did you ask Dr. Reisinger specifically between 1954 and 1958 what was the matter with you? A. No.

Q. You did not? A. No.

* * * * * * * * * *

45 By Mr. Spriggs:

Q. Now then, after you got out of the hospital after the pneumonia, can you give us the date you got out of the hospital? A. Well, I believe it must have been about the 3rd or 4th of March. As I recall, it was something like eleven days that I was in.

Q. Did you return to work after you were released from the hospital? A. Not for a few days. I had to stay home. And then I worked part time for a while.

Q. What was your condition during this period? A. Well, I always thought that I never quite got over the pneumonia.

Mr. Murphy: If Your Honor please, I think the witness ought to testify as to what her condition was as she observed it, not as she thought it was.

The Court: I think she is trying to give her impressions as to how she felt at the time. She may answer.

What is your answer?

• • • • • • • • • •

46 The Witness: Well, then was the beginning of the difficulty with my voice. I thought it was a part of the pneumonia, respiratory trouble.

• • • • • • • • • •

81 Q. For how long a period did your weight stay fairly constant? A. Beginning with when?

Q. Well, I understand your testimony to be that when you came to see Dr. Reisinger, you told him that your weight had been fairly constant for some time. A. Uh-huh.

Q. Did there come a time when it changed? A. Well, I weigh somewhat less now.

Q. Specifically, did there come a time when you weighed more? A. Yes.

Q. And when was that? A. That was, as I recall, in June of 1958. I know I weighed more than I had.

Q. And you continued to gain through that summer, didn't you, until you went to see Dr. Alpert? A. Yes.

• • • • • • • • • •

85 Q. Now, when you came out of the hospital in March of 1958, did you discuss your condition at all at that time with Dr. Reisinger, other than that you had had pneumonia? A. I don't recall. So far as I know, that was all.

Q. Between March of 1958 and June of 1958, did you consult any other physicians, other than Dr. Reisinger? A. June of what date?

Q. Eighteen. A. I wouldn't be sure. Somewhere along there I did talk to another doctor.

86 Q. And what was the name of this physician? A. His name was G. Haven Mankin, M-a-n-k-i-n.

Q. And was his specialty ear, nose and throat? A. That is right.

Q. And what complaints did you have for Dr. Mankin? A. I had this sore, this painful throat, difficulty in speaking, hoarseness; and I was afraid of cancer.

Q. I am sorry, I didn't hear that last. A. I was afraid of cancer.

Q. What examination did Dr. Mankin make? A. He used the glass tube down my throat, a tube with a mirror, and checked my throat to see if it were inflamed or anything of the sort; checked my nose.

Q. Are you finished? You seem to be hesitating. Are you finished? A. I am finished.

Q. Did Dr. Mankin prescribe any treatment for you? A. Just something to spray into my mouth to—a sort of a—well, I didn't know actually what it was. It was jst something to spray, to make my throat feel easier, I guess.

Q. Did you discuss with Dr. Reisinger that you had visited this ear, nose and throat man and had been

87 prescribed this spray? A. Yes, I did.

Q. Now, having that much in mind, does it bring back to your recollection any more clearly when in the period between March and June 18 you went to see Dr. Mankin? A. No.

Q. Well, when was it that you told Dr. Reisinger that you had seen Dr. Mankin? A. It was prior to June 18, I believe. I wouldn't swear to it. I just have no records.

Q. Did you tell Dr. Mankin that Dr. Reisinger had examined your throat? A. I don't know if I did.

Q. Did you tell Dr. Mankin that you might be taking some treatment for your throat? A. I don't recall.

Q. Did Dr. Mankin ask you to return for a follow-up check? A. No.

Q. Did Dr. Mankin give you any diagnosis as to what your condition was? A. No.

Q. Now, when you were discharged from the hospital in March of 1958, can you tell us precisely what your
88 physical condition was at that time, as you could observe it? A. I was extremely weak, fatigued, didn't have energy—well, I wasn't supposed to go to work immediately, but I didn't have energy either. Weakness and fatigue is what I recall.

Q. Do you recall any other symptoms? A. Well, it was the beginning of the difficulty with the voice.

* * * * * * * * * *

Q. When did you first notice a weight gain? A. I don't know specifically. I think it came on a little gradually, until all of a sudden I realized that I was heavier than I had been.

Q. Were you eating well during this period? A. When I put on the most weight, I had very little appetite.

Q. And this symptom was first reported to Dr. Reisinger on June 18, 1958? A. I beg your pardon?

89 Q. This symptom of weight gain with very little intake of food was reported to Dr. Reisinger for the first time on June 18 of 1958? A. He probably thought I had eaten too much before and tried to cut down, and when I found I couldn't, it didn't do any good.

Q. Let me try once more. This symptom was first reported to Dr. Reisinger on June 18 of 1958, is that correct? A. I don't remember. If it is there, yes.

Q. This also applies to the facial swelling, that this was first reported to Dr. Reisinger on June 18 of 1958? A. I think I had mentioned it before.

Q. When? A. Previously, previous visit.

Q. When was the previous visit that you mentioned it? A. I don't remember dates specifically, probably a week or a couple weeks before.

Q. Was it as much as a month before? A. It could have been.

Q. Could it have been six weeks before? A. No, I don't think so.

Q. Could it have been as little as a week before June 18? A. It is possible.

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90 Q. Do you recall what symptoms you detailed for the doctor when you visited him on June 18, 1958? A. Yes. My face was puffy; I was utterly miserable; complained my voice was thick, difficulty talking, my 91 legs probably bothered me. I don't remember if I told him at that time or not. I know they did during that time.

Q. Was your skin dry at that time? A. Yes.

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92 Q. Let's try between June 18 and the date when you saw Dr. Reisinger in July of 1958. Did you have any leg pains in that period? A. I had difficulty with locomotion.

Q. Did you have any difficulty with pains in your chest in that period? A. Yes.

Q. Do you recall whether you saw Dr. Reisinger once or twice in July of 1958? A. It is a long time ago. I don't recall.

Q. Do you recall an incident in July of a fainting spell while you were riding in a car? A. Yes, I fainted at work in March.

Q. Specifically in July of 1958? A. Yes.

Q. Did you give a history to Dr. Reisinger of having been riding in an automobile and fainting? A. Yes.

Q. What did you do in August of 1958? A. Relative to what?

93 Q. Specifically, did you take an automobile trip to Boise, Idaho? A. Yes, I did.

Q. And back? A. Yes, I did.

Q. You didn't see the doctor at all during August of 1958? A. I talked to him before I went away.

Q. When did you go away? A. I went away the latter part of August, must have been.

Q. When did you return? A. The 15th of September.

Q. How long— A. The 14th of September, actually.

Q. How long were you in Boise? A. About three weeks.

Q. How long did it take to drive out to Boise from Washington? A. I mean, the whole trip took three weeks.

Q. When you returned to Washington, you were referred by Dr. Reisinger to Dr. Alpert? A. Yes, sir.

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103 Q. All right. When you were in Minnesota, you testified that you went to see a Dr. Witthaus, was it? A. Yes.

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104 Q. Well, you on your own then went to see Dr.—I have forgotten—Ulrich, is it? A. Henry Ulrich. I have known him for twenty-five years almost.

Q. And Dr. Ulrich took a history from you? A. Yes.

Q. What did you tell Dr. Ulrich? A. I told him that I was—what my symptoms had been and how I felt, and I was on—that I was supposedly a myxedematist, and I wanted him to—I had palpitations in my head, I could not sleep, I was highly nervous because of the inability to sleep; and that is what I told him.

Q. When you say you told him about the symptoms which you had had, I assume that you told him about the symptoms you had in June of 1958? A. Uh-huh.

Q. Through the summer and about the pneumonia you had had in February? A. Yes.

Q. And you also told him that you had had the
105 iodine up-take test? A. Yes.

Q. And that Dr. Alpert had made a diagnosis of myxedema or hypothyroidism? A. Yes.

Q. Did Dr. Ulrich order any tests? A. Yes, he did.

Q. For your thyroid? A. Yes.

Q. What tests did he have done? A. He had two basal metabolisms.

Q. Did he tell you, as a result of those, that he did not feel that you had hypothyroidism? A. He said the tests were unsatisfactory in themselves and he did doubt that I had it.

Q. And this was after the two tests and all of the symptoms which you had related to Dr. Reisinger, you also had related to him? A. That is correct.

Q. Then when you were taken off this thyroid medicine by Dr. Ulrich— A. He said to discontinue it, yes.

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114 **John A. Reisinger**

was called as a witness by the Plaintiff and, having been first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Spriggs:

Q. Doctor, what is your name? A. John A. Reisinger.

Q. And what is your occupation? A. Physician.

Q. How long have you been a physician? A. Since 1926.

Q. Do you have a specialty? A. Yes.

115 Q. What is your specialty? A. Cardiology.

Q. Are you an internist? A. Yes.

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119 Q. Now, when Miss Baerman first came to you— do you recall when she first came to you? A. I have the records, that is all.

Q. Do you recall whether you took a history of her? A. Yes, sir.

Q. Did you reach a diagnosis? A. Reached the diagnosis, yes, in part.

Q. In part. What do you mean by in part? A. Well, we knew that her problem was that she had had a cardiac

problem incident to ligation of—incident to a long-standing patent ductus arteriosus and subsequent ligation which had imposed certain burdens upon the heart.

Q. Now then, what is the date that you made that diagnosis? A. February 27, 1952.

Q. What is a diagnosis, Doctor? A. When are you talking about?

120 Q. Well, a diagnosis in medicine—you read on a medical report, "Diagnosis." What does that mean? A. That means the nomenclature that is used to express the condition that exists.

Q. It is an art of determining the nature of a disease? A. There is a certain amount of art and experience involved in it, yes.

Q. There are several types of diagnoses, of arriving at a diagnosis, are there? A. Well, there are a great many factors that may go into arriving at a diagnosis, yes.

Q. Well now, what is a clinical diagnosis? A. Well, a clinical diagnosis is one that depends upon clinical findings as distinguished from laboratory findings.

Q. And clinical findings, are those the symptoms that are related to you by the patient? A. Those are the subjective findings but the objective findings are those that you find by listening, observing and palpation.

Q. Now, on your original diagnosis of Miss Baerman, then, in 1952, did you utilize those procedures which you just mentioned and arrived at that diagnosis? A. Yes.

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122 Q. She didn't have an enlarged heart when she first came to you in 1952, did she? A. Well, I think so.

Q. Well do your records show that she did? A. I stated in my fluoroscopic examination that the heart lies somewhat to the left so that the apex extends clear to the chest wall.

123 Q. Yes, but at that time you took a fluoroscopic examination of her, did you not? A. That is what I am reading from.

Q. You didn't show any enlarged heart there, did you? A. I think that would be considered an enlarged heart, if the apex of the heart extends to the chest wall, yes, sir.

Q. Is that what you call an enlarged heart? A. Yes, sir. The apex should not extend beyond the mid-clavicular line of the chest, which is in the midline.

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Q. Now, when Miss Baerman first came to you in February of 1952, did she give you a medical history? A. Yes.

Q. And did she tell you she had a history of
124 cardiac trouble? A. Yes.

Q. Did she tell you she had had heart surgery? A. She told me that she had had ligation of a patent ductus arteriosus, which is outside of the heart.

Q. What do you mean, outside of the heart? Can you explain that a little better? A. Well, it doesn't involve the heart per se; it involves the communication between the aorta and pulmonary artery, which is a normal communication up until the time of birth and should close after birth, but it doesn't always close. It is outside of the heart.

Q. Now, did she tell you also that prior to heart surgery she had had pneumonia? A. Yes.

Q. And then after February of 1952, on March the 17th, did you see her on that day? A. Yes, sir.

Q. And what was she complaining of at that time? A. She was complaining of pain in her chest and in her tooth.

Q. In her tube? A. Tooth, t-o-o-t-h.

125 Q. What did you give her at that time? A. I gave her some empirin and codeine for pain plus Stuart's Hematinic for iron and vitamins.

Q. Now then, I notice on your notes here in February 1952, you state here:

"Does not look anemic. Try more rest."

Was that your finding at that time? A. You are reading part of it. I said:

"Does not look anemic but get count."

Q. "But get count." You mean get blood count? A. That is right.

Q. Now, why would you get a blood count at that time? A. Because she looked anemic and she was complaining.

Q. And you wanted to make sure whether she did or did not have it, is that correct? A. That is right.

Q. So what did you do? A. I had a blood count done.

Q. Where? A. That was done at Kelso Laboratories.

Q. What date, do you recall? Do you have the record there? A. 3-14-52.

126 Q. Now, do you call that a laboratory diagnosis?

A. That is a diagnosis depending upon a laboratory finding, yes, sir.

Q. And you use a laboratory diagnosis as an aid when you, yourself, cannot determine what the condition is by looking at the patient, is that correct? A. That is correct. We use it as an adjunct or help.

Q. And that is the accepted practice in the District of Columbia, is it not? A. Yes.

Q. Now, did you ever use a laboratory test to determine whether Miss Baerman had myxedema? A. I never did, no. I had Dr. Alpert do it.

Q. When did you have Dr. Alpert do it? A. I will get the date. He did it on September 22, started the examination September 22, 1958.

Q. And that was the first time you knew then that she had myxedema? A. The first time I had laboratory evidence of it, yes, sir.

Q. Did you have any other evidence prior to 1958? A. We had clinical evidence or clinical suggestion that she

probably had some impairment of her thyroid func-
127 tion, yes.

Q. When did you have clinical evidence? A. In March 1958 she was started on thyroid substitute medication. March 21, 1958.

Q. Do you have all of your records there from 1952? A. Yes.

Q. Will you look at your records there on February the 1st, 1954. A. Yes.

Q. What was your finding on that day? A. At that time she was complaining of pain in her lower abdomen; she had had vaginal bleeding for over a week with some clotting, which was not like a normal period, last regular period having been three weeks before. She was also complaining of pain in her left upper chest but no pain on breathing, no shortness of breath. The blood pressure was 150 over 90; the heart rate was 80. Rhythm was regular; heart was enlarged; and there was a harsh systolic murmur at the base, especially on the left side.

Q. You say it says there that the heart was enlarged? A. The heart outside mcl. That means outside the midclavicular line.

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130 Q. What is the significance in relation to a patient's health? A. Well, enlargement usually results from a chronic strain, such as valvular lesion or a congenital heart lesion or hypertension. It imposes an added strain on the muscle, just like increased work causes any other muscle to enlarge.

Q. What did you treat her for on that date? Did you prescribe any drugs? A. What date are you referring to?

Q. I am referring now to February the 1st, 1954. A. I gave her iron preparation and an antihistamine praparation, Coricidin.

Q. And what is that for? A. That is for a respiratory infection.

Q. She had a respiratory infection then in 1954, is that correct? A. She had a head cold.

Q. She had a head cold. A. Yes.

Q. Now, Tregon, that is one of the drugs that you prescribed on that day? A. Tregon?

131 Q. Tregon. A. No, sir. Fergon.

Q. Fergon. What is that? A. That is an iron preparation.

Q. Is that for anemia? A. Yes.

Q. And now thyroid extract, what is that for? A. That is to supplement the thyroid secretion of the body.

Q. Now, what is a thyroid secretion? A. What is the thyroid secretion?

Q. Yes. A. Well, it is a—thyroxin is the chemical substance that is secreted by the thyroid.

Q. Does that go into the blood stream? A. Yes, sir.

Q. And its reaction on the blood stream is to build up the cells and the tissues, is that correct? A. Well, it is not really that simple. I can't—I don't believe I could tell you exactly how the thyroid acts except that it controls the rate of metabolism and the rate of oxygen utilization by the tissues.

Q. The thyroid secretion, is that produced by the

132 thyroid gland? A. That is right.

Q. And if it is not producing a sufficient amount, what is the reaction or what is the result on the patient? A. Well, there are various degrees of involvement with lack of secretion of the thyroid. The patient may not have any very definite symptoms. Fatigability, drousiness, sluggishness mentally are probably some of the early symptoms.

Q. Now, what do you call those symptoms. Are those clinical or physical or what, or subjective? A. That would be subjective.

Q. In other words, that is a history related to you by the patient? A. That is right.

Q. So at that time then, in February of 1954, you suspected that her thyroid gland was not performing its proper function, did you not? A. I thought that that—some of her symptoms might be due to that. In addition to her fatigability, she was also having quite a bit of menstrual disorder, irregularity, which sometimes is a result of inadequate thyroid or too much thyroid.

Q. So at that time, then, the physical symptoms which she related to you indicated a possible loss of thyroid
133 function? A. Right.

Q. Now, at that time did you send her to a laboratory? A. For what?

Q. For anything. A. I don't remember that I did.

Q. Doctor, before you could treat a thyroid condition or a thyroid deficiency, as you called it, you would have to make a diagnosis whether she did or did not have it, would you not? A. No, that is not always essential.

Q. What do you mean? A. Sometimes you can't make the diagnosis in the early stages.

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134 The Witness: At that time the only laboratory test that was available would have been basal metabolism.

By Mr. Spriggs:

Q. Did you send her for a basal metabolism test? A. No.

Q. You did not? A. No.

Q. And still at that time that was the one exclusive test you used to diagnose a deficient thyroid function, is that correct?

Mr. Murphy: If Your Honor please, that is not the testimony.

The Court: Well, he can answer it if it isn't.

The Witness: That is not. As I have said, the clinical findings and the history are equally important because the basal metabolism is not a dependable test.

By Mr. Spriggs:

Q. So it is used then in connection with your physical clinical examination? A. That is right.

135 Q. And your clinical examination, as you mentioned, you got from the patient herself and your own examination? A. That is right.

Q. And you state, then, that your physical findings on February the 2nd, 1954 indicated that deficiency in the function of the thyroid and so you gave her a thyroid extract, is that correct? A. I gave her a thyroid extract but I don't say any place in there that I—what was the basis for giving it. I suspected it was as much because of her menstrual irregularity as it was for anything else at that time.

Q. Well, did I understand you correctly a while ago to say that irregularity in the menstrual cycle was one of the symptoms of a deficient thyroid? A. Sometimes. It also is the symptom of other things, such as the menopause.

Q. Such as the menopause. Now, that is why it is doubly important in connection with your clinical findings to make a laboratory finding, isn't that correct? A. I made the laboratory finding by sending her to a gynecologist for an examination.

Q. When did you do do that? A. That was September 19, 1952.

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136 Q. Well, you mentioned a while ago that there were several symptoms, this menstrual irregularity could be due to menopause— A. (Witness nods assent.)

Q. —but you suspected a deficient thyroid, so you gave her thyroid extract. A. (Witness nods assent.)

Q. Now, if there are two or more causes for menstrual irregularity, wouldn't that make it essential in proper medical practice to use the laboratory examination with

137 your clinical examination? A. If the laboratory examination is going to be definitive and give you a

definite answer. It so happens that the basal metabolism is a very difficult examination for certain people, and from the experience that she had subsequently with basal metabolisms, we know that they would have been misleading rather than helpful.

Q. Now, is that any reason for not giving it?

Are you giving that as a reason for not sending her to have one made? A. Well, I am giving it partly as a reason but mostly because of her general nervous tendency, I doubted very much whether she would tolerate a basal metabolism or whether it would have been useful.

But aside from that, I didn't feel that that was essential at that time.

Q. Now then, in a basal metabolism test, all you do is blow your breath into a sack, isn't that right? A. No.

Q. What does it involve? A. It involves putting a mask over your face with a clip on your nose and inhaling oxygen.

138 Q. All right. A. And it has to be done without any leaks in the system and with the minimum amount of emotional or nervous tension on the part of the subject.

Q. Yes. But all it involves, then, is—when I draw my breath in, I am inhaling oxygen, aren't I? A. Yes, partly.

Q. All right. And all you are registering is the amount of oxygen I have inhaled there, isn't that right? A. That is right. Did you ever have a basal metabolism?

Q. Yes.

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By Mr. Spriggs:

Q. Now, Doctor, I noticed in your records here on March the 27th, 1952:

"Tired all through chest. Sleeps restlessly. No dyspena while walking one or two flights, cramp in legs."

Now, tired through the chest, isn't that another one of the clinical symptoms of a deficient thyroid? A. I don't think so, no, sir.

Q. It is not? A. Not necessarily, no.

139 Q. Well, is fatigue? Didn't you mention fatigue was one of the symptoms? A. Fatigability may be, yes.

Q. Is there a difference between tired and fatigability? A. Well, no, tired is the state. Tired in the chest is different from general fatigability.

Q. Tired is a chronic condition, is that correct?

The Court: What did you say, Doctor?

The Witness: Well, yes.

By Mr. Spriggs:

Q. And then on June the 3rd, 1952, you say:

"Just doesn't feel well. More than fatigue. Some chest pain. Back of the neck feels tense."

Will you read the rest of that there? A. "Sensation in back of throat like she had to swallow. Sleeps well, poor appetite. Fatigues more readily, lacks muscular energy. Can't hold self up when tired. Couldn't lift two-year-old child."

Q. What did you treat her for that time? A. She was given iron and vitamins then.

Q. But you did not give her a basal metabolism test? A. No.

140 Q. Now, on September 19, 1952, did you examine her again? A. Yes.

Q. What is the first thing you noted there? A. "Feels tired. Takes iron when she thinks of it."

Q. Where does it say that? A. Right after, "Feels tired."

Q. Well now, did you give her iron? A. I gave her iron, yes.

Q. That was September 19. And you gave her the iron then? A. On August 19, I gave her 2 cc's crude liver injection and ferrous gluconate, iron guleonate.

Q. You gave her that? A. I prescribed the ferrous gluconate.

Now, did you send her to another doctor at that time? A. Yes, sir.

Q. And it says there:

"Price was not able . . ."

What doctor did you send her to? A. I sent her to Dr. Cromer first and he was unable to do an examination, so I sent her to Dr. Price, and he was unable to to one until he had her under anesthesia.

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Q. And he advised her to go into the hospital for anesthesia and D&C, is that right? A. That is right.

Q. And you have got here—this is your writing, is it not:

"Thinks she may have something that ought to be checked."

A. That is right.

Q. What does that mean? A. Well, dilation and curettage—he feels that she should have the lining of the womb scraped out and examined mycroscopically to see what the cause of the bleeding was. That was why she was referred to him.

Q. And would you think that maybe cancer ought to be checked at that point? A. They would.

Q. They would? A. (Witness nods assent.)

Q. How would they check cancer? A. I say, the scrapings are removed and sent to the pathologist for microscopic study.

Q. There again we are using laboratory techniques to discover the cause of an illness, aren't we? A. That is right.

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Q. Now then, you examined her again in March of 1954, didn't you? A. Yes, sir.

Q. Did you say there:

"Legs ache, more or less constant, some swelling."

A. Yes, sir.

Q. "Weary at times. Periods regular. No abdominal pain, no chest pain. Took all the iron."

Do you read that? Say, "Took all the iron," doesn't it? A. I read it.

143 Q. That is your writing?

The Court: He said he read it, Mr. Spriggs.

By Mr. Spriggs:

Q. Now then, on June the 8th, 1954, you examined her again, didn't you? A. Yes.

Q. And at that time she had a feeling of pressure on the throat. Is that what her complaint was? A. Yes, sir.

Q. And did you at any time send her for a basal metabolism during this period? A. No, sir.

Q. Now, did you examine her again in April of 1955? A. Yes, sir.

Q. And at that time you say she didn't feel good but she was not fatigued, is that right? A. Yes, sir.

Q. But she didn't feel good? A. That is right.

Q. Now— A. She had an acute cold.

Q. An acute cold? A. That is what the record says.

144 Q. Did you give her any drugs on that occasion?

A. We gave her some Erythromycin, which is an antibiotic.

Q. For an infection? A. For an infection, yes, sir.

Q. That would be a respiratory infection? A. Yes, sir.

Q. Doctor, when a person has a deficient thyroid, they are very receptive to respiratory infections, are they not? A. Well, I don't know that they are particularly. She had other reasons for having respiratory infections.

Q. What was another reason? A. The principal reason was for almost forty years of her life she had had a condition in which the pressure in the right side of the heart and the lung circulation was high, which leads to changes in the pulmonary circulation, in the circulation to the lungs. And those people are more susceptible to infections.

Q. I see. And are also people with a deficient thyroid subject to them? A. Not that I know of, no, sir.

Q. Did you treat her throughout this period, then, from 1952 to 1958 for a heart condition? A. Well that was
145 her—that was her presenting reason for coming to me, but in the meantime she had, as you have already noted, a number of other things, anemia, respiratory infections, genital urinary infection, some menstrual difficulties, all of which had to be treated or someone else had to treat for us.

Q. When did she have anemia? A. The anemia we first noted on June 3, 1952.

Q. And when did she have the urinary infection? A. I think it was 1958.

Q. Now, you didn't treat her, then, for a heart condition during this period, is that right? A. Her heart did not require any treatment.

Q. The heart did not require any treatment, then, from 1952 to 1960, is that right? A. That is right.

Q. So you weren't treating her, then, for a heart condition? A. I wasn't offering any treatment. I was observing her for possible changes in her heart that might require treatment.

Q. If you weren't treating her for her heart condition, that leaves, then, that you were treating her throughout this period for an anemia and urinary infection, isn't
146 that right? A. Well, those were incidental things.

Q. Well, were there other things? A. I suppose the most frequent complaint that she had was respiratory infections.

Q. Respiratory infections and fatigue, wasn't it? A. Well, she usually complained of fatigue, yes.

Q. She had that complaint throughout this entire period, did she not? A. I think so although we noted one place where she wasn't tired.

Q. When was that? A. Well, you called attention to June 8, 1954 when we said that she had no unusual fatigue.

Q. Yes. That means she wasn't—"unusual" then means that it wasn't worse, doesn't it? A. Well, she obviously wasn't unusually tired for her.

Q. For her, meaning then that usually she is tired? A. That is what she said. I can't answer for that.

Q. That is what she said. Now, did you send her for a basal metabolism test during 1955? A. No.

Q. Did you send her for a basal metabolism test in 1954? A. No.

147 Q. Did you send her for one in 1956? A. No.

Q. Did you send her for one in 1957? A. No.

Q. Did you send her for one in 1958? A. No.

Q. In 1958? A. I did not send her for a basal metabolism, no.

Q. Did you send her for one in 1953? A. No.

Q. You say you didn't send her for one in 1958, either, is that correct? A. Not for a basal metabolism, no.

Q. Did you send her for any other test? A. Yes.

Q. What was that? A. Radioactive iodine up-take test.

Q. And what is that for? A. That is to determine the activity of the thyroid gland.

Q. When did that first become popular? A. I can't say for sure. It still isn't exactly popular. But it is
148 probably in the neighborhood of 1957 or 1958 when it was available in Washington.

Q. And always before that they used the basal metabolism test? A. That is right. That was one of the—

Q. Where did you send her to have this radioactive iodine up-take test? A. I sent her to Dr. Louis Alpert at the George Washington University Hospital.

Q. Why did you send her? A. Dr. Alpert is an endocrinologist and George Washington was one of the few places that had the facilities for doing the 131 up-takes.

Q. Did Kelso have those facilities? A. No, sir.

Q. Dr. Kelso? A. No, sir.

Q. How long has Dr. Alpert been in practice, do you know? A. I don't know.

Q. Do you know what his specialty is? A. He is an endocrinologist.

Q. When did you send Miss Baerman to him? A. September the 22nd, 1958.

149 Q. When did you first decide to send her to Dr. Alpert? A. I don't have any way of knowing when I decided to send her, although apparently I planned to do it in June 1958 because I have written down, "Rule out hypothyroidism."

Q. Rule it out in 1958? A. That is right.

Q. And is that on your record here?

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151 Q. Now, the same symptoms, if you were treating the same symptoms for a period of two years, wouldn't good medical practice in the District of Columbia indicate you should send her to another doctor? A. No. I see patients every day who have chronic heart disease who have the same symptoms and have had for many years and will continue to have the same symptoms but they can't be improved by seeing somebody else.

Q. But you stated that she didn't have a heart condition. A. I didn't say she didn't have a heart condition.

Q. You said you didn't treat her for a heart condition. A. I said it didn't need treatment.

Q. The heart condition didn't need treatment.

152 A. That is right.

Q. The only thing that needed treatment, then, was the condition of the thyroid deficiency? A. Well, she had other treatment besides that, as we have already outlined.

Q. You treated the anemia? A. That is right.

Q. And she responded to that, did she not? A. After she also had been treated for her pelvic condition.

Q. Yes, but then she responded to the treatment for anemia? A. Yes.

Q. And her blood count got up, is that right? A. Improved, yes.

Q. In other words, did it go back to normal? A. Well, it had a fairly good count, as I remember it. In June 1958 her hemoglobin was eighty-two per cent, which is a pretty fair count for a woman.

Q. Then you cured her of the anemia? A. Improved it.

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153 Q. Did you in that Workmen's Compensation hearing testify? A. Yes, sir.

Q. And did you state at the Workmen's Compensation hearing that you first suspected she had hypothyroidism in 1954?

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A. The question was:

154 "You stated there that you first noticed she had that in 1955, didn't you?

"Answer: I don't think I stated it today but we have back as far as 1954 I suspected she had hypothyroidism because of her . . ."

Then I was interrupted. And the question was:

"When did you know it?"

I said:

"1958."

Q. But you suspected it in 1954? A. That is what it said, yes, sir.

Q. And yet you did not send her to any laboratory to find out whether she did or did not have it? A. No.

Q. And you, a practitioner, a doctor in practice in the District of Columbia, cannot treat a disease until he knows what it is, can he?

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159 Q. Now, you say there are degrees of hypothyroidism. A. Yes.

Q. And we are definite on that? A. Yes.

Q. Then that means that the quicker you start treatment the less severe it becomes, isn't that correct? A. Not necessarily, no.

Q. Well, does it get worse if you start treatment
160 early? A. It may not get any worse, no. But if you start treating early, you may precipitate a greater thyroid insufficiency.

Q. How do you do that? A. By decreasing the normal thyroid secretion.

Q. But you don't know whether she had a normal thyroid secretion, do you? A. No.

Q. And you didn't know that in 1954? A. No.

Q. Now then, getting back to February of 1958, did Miss Baerman have pneumonia that year, do you recall? A. Yes, it was so diagnosed. It was an atypical pneumonia.

Q. And when was that? A. She was in the hospital from February 20 for eleven days.

Q. And what was her condition after she got out of the hospital? A. Well, she said she felt miserable but was working every day, fatigued at the end of the day, still coughing some, denied smoking, throat is sore.

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161 The Witness: The last visit before then was February 7, 1958, and she said she was feeling some better, which meant that she was getting over a respiratory infection, but she was tired, resting better, sleeps without sedative, has had a cold since August, coughs, slight hemoptysis, nose stuffy, not too dyspneic, no orthopnea.

Q. What does that dyspneic mean? A. Short of breath.

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164

Saul Rosen

was called as a witness by the Plaintiff and, having been first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Spriggs:

Q. What is your name? A. Saul Rosen.

Q. And what is your occupation? A. Physician.

Q. Where do you practice? A. I do clinical investigation at the National Institutes of Health.

Q. How long have you been doing so? A. Since 1958 with one year off.

Q. Now, are you an internist? A. I am a Board-eligible internist. I have passed Part 1 of the National Boards.

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165 Q. Now, did there come a time when you examined a Miss Katherine Baerman? A. Yes.

Q. Do you recall when that was? A. May I consult my notes?

Q. Yes. A. O.K. I first saw Miss Baerman in 1959 in August.

Q. And where? A. In the clinical center of the National Institutes of Health.

Q. Do you have your record there of when she was admitted? A. Yes, she was admitted on July 30, 1959.

Q. July 30?

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168 Q. Objective tests, what are they? A. Well, that is laboratory. An objective test is one which doesn't require subjective interpretation on the part of the physician.

A physical examination or many parts of it would be a subjective test. An objective test would be laboratory determination, blood test, examining circulating thyroid

hormone, X-ray determination of how much radioactive iodine up-take in the area of a person's thyroid gland, and so forth. These are objective tests.

Q. What is the purpose of objective tests? A. To eliminate subjective error as far as possible.

Q. Eliminate subjective error? A. Yes, as far as possible.

169 Q. I see. And that is what the hospital gave her? A. Well, we did other things as well. We took a history and did a physical and did laboratory examinations, the usual complete work-up.

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171 Q. What action does thyroid hormone have upon the person's body? A. Thyroid hormone will increase the metabolic rate; it will decrease the serum cholesterol; it will increase the activity of the heart; it will in the adult preserve the maintenance of the normal voice.

I can better tell you what thyroid hormone does by citing what happens in the absence of thyroid hormone.

Q. What does happen in the absence? A. Myxedema or hypothyroidism—the two are sort of used interchangeably —will result in patients feeling sluggish; there will be a lack of pep; there will be tiredness and sleepiness,

172 inability to concentrate; the skin will get thickened and cool; the basal metabolic rate will fall, the serum cholesterol concentration will rise; they may develop edema, that is, accumulation of watery-like material under the skin, particularly in the legs; they may develop shortness of breath; they may develop enlargement and poor performance of the heart.

Q. If a patient has those symptoms, those are what you call objective symptoms, are they? A. Some are objective and some are not. Naturally, if you see a person who is complaining of lack of pep, this is, you know, quite subjective. Can be anything at all from a depression to frank lack of thyroid hormone. Edema in the legs, which you

can feel and put your finger into and see the pits is more of an objective physical finding.

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173 Q. What does cause it to become atrophied? A. There are a large number of causes of myxedema, hypothyroidism. The principal cause, in all candor, is unknown. It represents medical ignorance in 1965. We don't know what causes most cases of myxedema. They just occur.

There are known causes of myxedema, hypothyroidism, such as a disease called thyroiditis, an "itis" an inflammation of the thyroid gland, which can be caused by a viral infection, can be caused by a condition believed now to represent some immune disorder on the part of the body handling this. Tumors of the thyroid gland can cause hypo functioning of the gland. Involvement in obliteration of the gland by various granuloma processes, that is a medical term meaning the accumulation of inactive nodules in an area as a result of, say, some fungus infection or
174 some unknown disease like sarcoidosis can rarely cause this. There are also inborn errors of metabolism. People are born occasionally with thyroids that are unable to function. Most cases of myxedema are idiopathic, that is, we are unsophisticated at the moment to pinpoint the genesis.

Q. You cannot pinpoint it accurately, is that what you mean? A. We don't know what causes it.

Q. You have known of the disease for many years, is that right? A. Hypothyroidism is an ancient disease.

Q. It has been prevalent since the history of medicine? A. I am not expert on the history of medicine but it has been well known for a long time.

Q. There are certain tests that are taken to rule it out? A. There are tests of thyroid function. There are a lot of tests of thyroid function.

Q. How many tests are there? A. I can't give you a number. There are different tests that measure different

things. The test I was discussing before measures the ability of the thyroid gland to attract radioactive iodine. The blood test measures circulating thyroid hormone. Metabolic rate measures the response of the tissues to thyroid hormone.

Q. They are all laboratory procedures, are they
175 not? A. Yes.

Q. Anything other than a laboratory procedure, you say, would just be your own observation? A. Yes, which can frequently be quite good.

Q. Now, would a person with a deficient function of the thyroid be subject to respiratory diseases? A. I don't feel really competent to give you a good answer on that. My off-the-cuff impression, as an internist and sort of a general endocrinologist, whose speciality is not the thyroid gland, I might hasten to add, is that this is not—I would guess, no, but that is not an expert opinon.

Q. It is not an expert opinion? A. That is correct.

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177 Q. Is myxedema curable? A. Depends on how you define curable. It is treatable. You can treat people with hypothyroidism with thyroid hormone and they can frequently regain their status, their subjective feeling of well being that they had before they acquired myxedema. But curable in the sense that if they stop taking medicine, they would be O.K., you can't cure them.

Q. Then under those circumstances it would be
178 important to catch the condition as soon as possible, isn't that correct? A. Well, I guess it is desirable to catch every condition as soon as possible.

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By Mr. Murphy:

Q. Doctor, when you mentioned these objective tests, that the purpose was to eliminate error, there are errors inborn in many of the objective tests, are there not? A. Absolutely.

Q. Did the NIH run a basal metabolism test on Miss Baerman? A. Oh, I guess we do it. I can look it up. It is one of the less reliable tests. It is sufficiently unreliable maybe Dr. Paston didn't order it and I didn't.

Yes, here it is, minus 3 per cent.

Q. Does that indicate hypothyroidism? A. That is within the normal range of acceptability for the basal metabolism and it is unreliable. The other test showed she was clearly hypothyroid.

Q. I understand. And from the basal metabolism, it did not indicate hypothyroidism? A. That is correct.

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179 **John A. Reisinger**

resumed the stand and testified further as follows:

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180 By Mr. Murphy:

Q. Doctor, at the close of your examination by Mr. Spriggs, you were asked where you noted any time when Miss Baerman was not fatigued.

Will you refer to your entry for April the 29th of 1955, which I believe was inquired into by Mr. Spriggs. A. April 29?

Q. It looks like April 29, '55. A. Yes.

The Court: What is the question?

By Mr. Murphy:

Q. Is there in that entry a notation that on that day she was not fatigued? A. Yes.

Q. I believe Mr. Spriggs examined you at length about the entry for March 24 of 1954, eliminating the first entry. Will you state what that first entry is for that date? A. "Feeling better."

Q. Now is cardiology a subspecialty of internal medicine and can endocrinology also be a subspecialty of internal medicine? A. Yes, sir.

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185 **Richard E. Kelso**

was called as a witness by the Plaintiff and, having been first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Spriggs:

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192 Q. Can you give us the tests that you used to determine a patient's condition for hypothyroidism, for example? A. Well, the tests that we were using at that time and at the present time are the basal metabolism test, the protein-bound iodine test, usually referred to as the PBI.

193 Any others? A. During this period there were several that were in the research stage, now being used. At that time, as I recall, these tests were not used in the ordinary clinical laboratories.

Q. By that you mean you did not use them in your laboratory? A. That is correct.

Q. Now, this protein-bound iodine, that was in existence at that time? That was used—when was that used, what year, do you recall? A. Well, the first work, as I recall, came out about 1951 but it wasn't universally used until about 1953 or '54.

Q. I see. Now then, what about the iodine-bound uptake test, when did that first come into common practice? A. Roughly, a little later than that. One of the radio isotope techniques, and it became popular about 1957, I would say.

Q. Didn't it come out in 1954 and 1955?

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194 Q. Now, the machinery you used, then, was the basal metabolism test? A. Yes, sir.

Q. How long has that been in use? A. I can't tell you exactly, Mr. Spriggs, but I would say probably since

perhaps 1920, maybe even perhaps earlier than that. This is the basic procedure.

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196 Cross Examination

By Mr. Murphy:

Q. Dr. Kelso, is the basal metabolism test considered a reliable test? A. Not—no, it is not a reliable test, not as commonly done. It is basically—done under proper conditions, it may well be considered a good test. But unfortunately, the environment and the preparation and the manipulation of this test is such that it has been extremely difficult to obtain accurate results.

As a matter of fact, we practically do no BMR's any more. It just is a test that has fallen into disrepute because of the fact of the technical problems.

To do the test properly, why, you should at least do three different tests on three different occasions on
197 the patient and this, of course, becomes a disturbing factor for the patient as well as the cost being prohibitive. As a result, it has, as I say, just been discontinued in use by almost all laboratories and hospitals throughout the country.

Q. Do you recall precisely when your laboratory began doing protein-bound iodine tests? A. I can't tell you exactly but I believe—I just believe we started about 1956. This test also is a very difficult procedure and up until three years ago we sent this material out to a laboratory in California. As a matter of fact, up until three years ago the Johns Hopkins Hospital and many of the large hospitals in New York City were sending their material out to California because of the intricacies and the difficulties in getting good PBI tests.

We are now doing them in our own office.

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202 **Louis P. Levitt**

was called as a witness by the Plaintiff and, having been first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Spriggs:

Q. What is your name? A. Louis P. Levitt, M.D.

Q. Are you a licensed physician in the District of Columbia? A. Yes.

Q. Are you in private practice? A. Yes.

203 Q. Where is your office located? A. 411 Hamilton Street, Northeast.

Q. Are you a graduate of any medical college? A. Yes, University of Colorado Medical School, Denver, Colorado.

Q. Where did you serve your internship? A. At Saint Elizabeth's Hospital, Columbia Hospital for Women and Children's Hospital in Washington, D. C.

Q. Now, what type of practice do you have at the present time? A. General practice.

Q. General practice, what is that? A. Just the practice of medicine generally speaking, for all types of individuals.

Q. You have no specialty? A. No.

Q. Now, in your practice of medicine, have you ever had an opportunity to treat people with a hypothyroid condition? A. Yes.

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204 Q. Now then, the physical or clinical findings, what
205 do they consist of? A. Well, a low blood pressure and a dry scalp and falling of the hair and a swelling of the skin of the face, thickness of the tongue, apathy of a patient, a tendency toward drowsiness, lack of energy and vitality.

Q. Now then, those are the symptoms, are they, the physical symptoms? A. Those are the physical symptoms.

Q. Now, if you have the physical symptoms which you mentioned and you suspect a deficiency in the thyroid

function, what is the next step a doctor must do to treat his patient? A. Well—

Mr. Murphy: I object, Your Honor. This is a hypothetical question and it doesn't contain all the matter that is in evidence.

It is not a proper hypothetical question, to begin with, in form.

The Court: I will sustain the objection.

By Mr. Spriggs:

Q. Well now, Doctor, do you in your practice use the laboratory to assist you in your diagnosis?

Mr. Murphy: I object. That is not an issue in this case.

The Court: Yes, I will sustain the objection to
206 that question.

Mr. Spriggs: I believe it is.

The Court: Will counsel come to the bench, please.

(Whereupon counsel approached the bench and the following proceedings were held:)

The Court: I don't think whether this doctor uses the laboratory test is the issue in this case. But I am concerned about your question before that. I think that you can phrase a hypothetical question which will be sufficiently comprehensive to elicit from the doctor what is the accepted practice in the community under similar circumstance, it would seem to me.

Don't you think he can do that?

Mr. Murphy: I think he can. I would like on the record to make an objection to this doctor giving an opinion as to what a cardiologist would do in a situation. I don't think he is competent to testify.

I realize this is within the discretion of the Court as to whether he can or cannot.

The Court: Well, I think if you properly phrase your question, you can elicit from him what is the practice in the community among experts in this particular field.

No, I don't think you can because he is not an
207 expert in the field.

Mr. Spriggs: I can ask him the hypothetical question.

The Court: I am not sure about it now. I am not sure he can testify as to what is the practice among those who are expert in the field because he isn't, he is a general practitioner.

Mr. Spriggs: Yes, but he doesn't have to be an expert to treat hypothyroidism. He has treated hypothyroid conditions himself in his private practice and he has so stated. He can certainly testify as to what the practice is, what he does.

Mr. Murphy: In this case—

The Court: I don't think so. I don't think what he does is really in this case at all, what an individual doctor does.

Mr. Spriggs: Well, it is certainly relevant to the established practice in the District.

The Court: Not just what one doctor does. It doesn't establish it is the practice.

Mr. Spriggs: It has relationship. He is practicing in the District of Columbia.

The Court: I don't think so, Mr. Spriggs. I don't
208 think what he does establishes the practice among the profession generally in the District of Columbia.

Is that your point?

Mr. Murphy: That is part of my point on the question. Another objection I would have to the question that was asked is that we are not dealing with this in a vacuum. We are dealing with a woman who had all these other conditions.

If he is going to express an opinion—I don't think he can express an opinion, but if he is going to try, he has to know all the conditions which this doctor had before him.

The Court: I will sustain the objection.

(Whereupon counsel resumed their places and the following proceedings were held:)

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211 Q. Now, Doctor, in your practice, let me assume that a patient, fifty-five years of age, comes into your office in 1952, gives you a history at that time that she had had an operation on the heart in San Francisco in 1948, and she came into your office in February of 1952 and gave you that history, and she continued to come to your office each year several time a year from 1952 to 1958, that the main symptoms which she had were: I am tired; I am tired; fatigued; there is difficulty with the menstrual function; and the main symptom is fatigability and menstrual irregularities.

You treat her for anemia; and you, in 1954, suspect that she has a condition of deficiency in the thyroid gland.

212 You base that upon the clinical or the history as related to you by the patient, but you at that time, when you suspect the hypothyroid condition, do not send her to a laboratory to find out whether she did or did not have that condition. And you continue to treat her for anemia and respiratory infections.

Do you have an opinion with any reasonable degree of medical certainty whether that would be accepted practice in the District of Columbia?

Mr. Murphy: I object, Your Honor.

The Court: Objection sustained.

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222 **Louis K. Alpert**

was called as a witness by the Plaintiff and, having been first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Spriggs:

Q. What is your name? A. Louis K. Alpert, A-l-p-e-r-t.

Q. What is your occupation? A. Physician.

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231 The Witness: I would say that if the clinical suspicion or clinical impression of the doctor, that is,

his impression about what the status of the thyroid is on his examination is strong enough that the patient has hypothyroidism, I would say that most of the time he would have a laboratory test done unless there were certain factors which would contraindicate it or which would perhaps make it unnecessary.

There may be perhaps the cost of the tests involved which may be beyond the patient's means. At that time the reliability of the laboratory tests might have been in question. They have been improved in recent years. In the early 1950's the precision, the reliability of the tests was not as good as it is today.

The diagnosis or impression of hypothyroidism, when the clinical features of the patient are sufficiently strong, rests in large measure on the experience of the physician as to whether those features fit rather closely to his previous experience in connection with hypothyroidism.

There are well-documented instances when the laboratory tests have been, let's say, in the lower range of normal, when someone who had not seen the patient would say, well, this is within the normal range and, therefore, does not establish a diagnosis, yet in actual fact that
232 patient may well have hypothyroidism. And it then becomes incumbent upon the physician to treat that patient accordingly.

I think that the clinical impression of a well-qualified physician is very important and can sometimes outweigh the laboratory results.

By Mr. Spriggs:

Q. Would you say, then, when a doctor makes a diagnosis that a patient has a hypothyroid condition, it becomes incumbent upon that doctor to take all steps available to treat that patient? Is that right? A. If he has a high degree of assurance in the sum total of his own opinion about the condition of the patient, that is, in reference to that particular element, I would say, yes. If there are

no other factors which conceivably might mitigate against administration of thyroid.

A competent physician must consider not only the one system that he is looking at, the thyroid in this instance, but other factors in the patient, too.

I am not sure whether I have answered your question.

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233 By Mr. Spriggs:

Q. Doctor, did you examine Miss Baerman yourself?

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Q. What did you examine her for? A. For a possible hypothyroid condition.

Do you wish me to read my notes?

Q. Yes. A. On that date I said as follows:

The patient is a forty-five-year-old female who gives a history that in February 1958 she had pneumonia, was hospitalized for eleven days. She had a cough at that time but no sore throat or difficulty in swallowing.

234 Following the pneumonia she noticed that she did not pick up her normal strength and felt continuously tired. She also had a tendency to fall asleep after her return home from work.

Her occupation is that of a switchboard operator and she noticed some difficulty in speaking and that her speech was slower and it was sometimes forced.

She gained weight from 107 pounds to 117 pounds without any change in diet. Her skin has been dry; bowels irregular.

On examination the patient appears quite sluggish and the eyelids are puffy. The skin is rather dry, especially over the elbows. The thyroid gland is small. The reflexes are somewhat reduced.

The history and findings are compatible with hypothyroid. The patient will have a radioactive iodine uptake test done and the report sent to Dr. Reisinger.

Next note:

Radioactive iodine up-take test was five per cent, which was compatible with the diagnosis of hypothyroidism. She will return to the care of Dr. Reisinger, who will be advised regarding the treatment with thyroid and Cytomel.

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236 By Mr. Spriggs:

Q. And a clinical impression is based solely upon the symptoms as related to you by the patient? A. No. It would include the physical examination. That would be very important.

Q. The physical examination? A. Yes.

Q. And the symptoms that you observed on physical examination? A. Yes.

Q. And the history? A. Yes.

Q. Is that what you mean when you say clinical examination? A. Yes.

Q. You use the laboratory, then, to determine your diagnosis which you found clinically? A. To confirm it.

237 Q. Yes. A. Yes. I, personally, never use the laboratory alone to make a diagnosis. I think this is not proper. I think it should be used for the confirmation of a clinical impression.

Q. Right. And by the same token, you cannot be sure of a clinical diagnosis until you use a laboratory, is that correct?

Mr. Murphy: If Your Honor please, I think he is arguing with his own witness.

The Court: No, he may answer.

You may answer.

The Witness: Well, as I tried to indicate before, I don't believe that a competent physician, if I may say so, should depend entirely on a laboratory test to establish a diagnosis.

If that were the case, if I am not deviating too far, then the services of the physician to the patient becomes

secondary. The laboratory then becomes dominant in deciding what is wrong with the patient.

The function of the physician is to see the patient and make an assessment of what is wrong and determine which if any laboratory tests are necessary. Laboratories are not
238 infallible. They have a certain amount of chance of error. When a physician receives the report from the laboratory, it then becomes his responsibility, not the laboratory's, but his to determine whether this laboratory result is acceptable, whether this is adequate to confirm his diagnosis.

I may say that there have been occasions when I, myself, have decided to adhere to my clinical diagnosis because I felt sufficiently certain about it, even though I could not confirm it on laboratory test. This is accepted.

By Mr. Spriggs:

Q. When you state that the laboratory is not infallible, a doctor's diagnosis is not infallible either, is it? A. That is correct.

Q. And you use the laboratory to check out the validity of the doctor's diagnosis? A. I don't think I would put it in that way, no.

Q. Isn't that— A. At least this is not my personal approach to this problem.

Q. I see. A. Now, if I may quote Sir William Osler, who is a famous physician whom you may have heard of, he said:

When a laboratory test confirms your clinical diagnosis,
239 then you may accept it. If it does not confirm your clinical diagnosis, then it is best to disregard it.

And he was a great physician.

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Q. Now, Doctor, what are the tests that you use in a laboratory to confirm your clinical diagnosis of hypothyroidism?

Mr. Murphy: Can we find out when we are speaking of?

By Mr. Spriggs:

Q. Let's start with 1954.

Mr. Murphy: Excuse me. I should have appended one more thing. I think we ought to stick to the District of Columbia, as well.

By Mr. Spriggs:

Q. In the District of Columbia, yes. We will
240 confine it to the District of Columbia. A. Well, the basal metabolism test, of course, is an old test that dates back to the 1920's. I am sure it was available then.

The radioactive iodine up-take test, which I referred to here in 1958, was available in some hospitals, not all.

Another test which is referred to as the protein-bound iodine test, or PBI for short, was beginning to be available then, but there was great difficulty in the reliability of the test.

The early attempts of the laboratories in the District of Columbia to establish this test almost failed because it is technically a very difficult or, if I may use the term, a tricky test. It was apt to go wrong quite often. This has recently been improved.

Q. You are speaking now the iodine up-take test? A. No, the iodine up-take test, which our laboratory first began to develop in 1950, I think,—was the first laboratory in the District of Columbia to do so—it was still on an experimental basis but it had become more accepted as the years went by. I am not sure about the date but it may have been more widely used by 1954. Certainly by 1958 it had become pretty much standard.

Q. And prior to the time that that became pretty
241 much standard, they relied on the basal metabolism test, is that correct? A. Yes.

Q. And that was the only test that medical knowledge had available at that time? A. Yes, that is correct.

Q. These other two tests which you mentioned, the

protein-bound iodine and the iodine up-take are improvements over the basal metabolism? A. Yes, they are.

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249 Q. Does the giving of this thyroid artificially ever have a depressive effect on a thyroid gland? In other words, does it cause at any time a tendency of the thyroid gland to cease to produce natural thyroid? A. Yes, it can. Even in the normal individual this is a sort of a built-in mechanism whereby the individual, the human body protects itself. There is a balance that develops. The more thyroid which a normal individual would take, let us say, the more his own thyroid is temporarily suppressed, doesn't put out so much hormone. So that a balance is maintained. If at some later time that individual discontinues taking the thyroid medication, and if his own thyroid gland is still normal, it will recover in a sense, it will come back to its normal level of producing thyroid hormone over a period of weeks or months.

250 In the patient in whom there was initially some degree of loss of their own thyroid function, then that suppression will be corrected only to that point, unless in the meantime there has been a further intrinsic damage.

What I am getting at is that the thyroid medication suppresses the function but does not damage the thyroid gland. Whatever goes on in the thyroid gland goes on because of other conditions that have developed within the gland itself.

Q. The gland doesn't atrophy when it is not used, as a muscle might? A. Temporarily it does.

Q. And atrophy is shrinking in size, is that correct? A. That is correct.

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By Mr. Spriggs:

Q. Doctor, if you have a thyroid gland that doesn't produce a sufficient amount of hormone, and you don't treat it with any medicine, what happens to it? A. Well, it probably would remain in the same condition.

Q. Wouldn't it become atrophied? A. Whether it does or not, as I tried to indicate a moment ago, is due to
251 conditions that have developed within the thyroid gland, in the patient, and not to whether or not they receive medication.

This is perhaps a difficult thing to explain. I don't think I am explaining this correctly. But if such a condition begins to develop, it is because of something that is going on within the thyroid gland, itself, that is gradually producing this damage.

Replacing the thyroid with thyroid medication, what that lack is, will neither delay nor accelerate that significantly.

Q. But without any medicine— A. The process would remain the same. That wouldn't be altered.

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252 By Mr. Spriggs:

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Q. Now then, the mere fact that a basal metabolism test, as you mentioned a while ago, was not entirely accurate, is no reason not to use it, is it? A. I think that is a matter of opinion for the individual doctor.

If I might express my own personal opinion, I might say that since these other tests have become available, I no longer use the basal metabolism test at all, for the reason which I stated before. Other physicians in the District of Columbia still use the basal metabolism test under very particular conditions.

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255 **Vincent Paul Sweeney**

was called as a witness by the Plaintiff and, having been first duly sworn, was examined and testified as follows:

Direct Examination

By Mr. Spriggs:

Q. Doctor, what is your name? A. Vincent Paul Sweeney.

Q. And what is your occupation? A. Doctor of medicine.

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262 Q. Taking those categories which you mentioned, you mentioned the iodine up-take test. A. Protein-bound iodine, which is a measurement of the blood circulating thyroid. How much thyroid the gland is putting out and into the blood.

Q. And how long has that been available? A. I went back in the records of our office as to when this test was being used by us in our office. This was before I was in my office, my present office. They became in general use, as far as our office was concerned, in 1958.

Q. 1958?

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264 Q. I see. Is a hypothyroid condition curable? A. Curable?

Q. Yes. A. It is curable in that you can replace the deficiency of the body, yes.

Q. And is that the only way it is curable? A. I think "curable" is the wrong word. I think it is replaceable. You can replace the deficiency of the body. You don't cure the basic disease in the thyroid.

Q. What is the basic disease of the thyroid? A. Well, it depends on the cause of the myxedema. The most common cause of myxedema is due to a gradual diminution of the thyroid's ability to form hormone for some unknown reason. It involutes, it becomes non-functioning slowly.

There are other causes from which this can happen on a more rapid basis. Diseases which can directly involve the thyroid gland and destroy enough thyroid tissue that the gland is no longer able to elaborate the hormone and
265 put it into the blood stream.

Q. Can you give us an example? A. An example of the more rapid type?

Q. Yes. A. It would be Hashimoto's disease, which is an inflammation of the thyroid gland, which may destroy the thyroid gland tissue quite rapidly; and the patient may become hypothyroid or myxedematous on a very rapid basis as opposed to the more incipient, gradual and subtle changes that occur in the other type.

Q. Now, if there were a deficiency in the thyroid function, is it important to determine that and to put the patient on treatment as soon as possible? A. Yes, depending—you have to take the whole patient into consideration. There are many people who are deficient in thyroid and for whom it is maybe in their best interest that it not be completely replaced.

Citing as an example someone, for instance, with heart disease, coronary artery disease, who was myxedematous, it would not be in the patient's best interest merely to correct the thyroid condition at the expense of perhaps accelerating the heart action.

In fact, there are some people who have heart
266 conditions who are rendered myxedematous deliberately so there is less stimulus in the heart.

Apart from examples like that, it would be desirable to replace the deficiency that the patient had.

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303 The Court: Good morning.

Members of the jury, as I think I indicated to you yesterday afternoon, counsel for the Plaintiff advised the Court that the Plaintiff's case was closed, that is, he had no further testimony to offer or any witnesses.

At that time counsel for the Defendant moved for a directed verdict in favor of the Defendant on the ground that there is no evidence in the case to support the Plaintiff's claim.

I told you several times during the course of this trial that you were the sole judges of the issues of fact in this case and that you base your judgment solely upon the evidence which you heard during the course of the trial.

304 Sometimes a case develops where the Court does not submit it to the jury, where if there is no evidence of negligence as a matter of law, then the defendant has a right to move that the Court direct a verdict in his favor, putting up to the Court the responsibility of deciding this case and relieving you of the responsibility.

That was done in this case yesterday. After you left, I had the opportunity of hearing from counsel for the Plaintiff and counsel for the Defendant and discussing the law and also discussing the evidence as it applies to the law. They were full in their arguments. I requested them to be so.

I had an opportunity to make further study of the record overnight and the conclusion which I have reached is that the motion of counsel for the Defendant must be granted because there is no evidence of negligence on the part of the Defendant doctor.

This is a malpractice case, and on a motion for a directed verdict in a malpractice case, the evidence must be construed most favorably to the plaintiff. To this end, she is entitled to the full effect of every legitimate inference therefrom. If upon the evidence so considered reasonable men might differ, the case should go to the jury.

Malpractice in hard to prove. The physician has
305 all of the advantages of position. What might be considered light evidence when there is no such advantage, as in ordinary negligence cases, takes on greater weight in malpractice suits. Generally speaking, direct and positive testimony to specific acts of negligence is not required. There are many instances where the facts alone prove negligence and where it is unnecessary to have expert opinion to show unskillful and negligent treatment.

In this case, however, due to the complexity of the illness involved, that is, hypothyroidism or myxedema, I am of the opinion that the evidence of medical experts is required to prove the Plaintiff's case.

In order to establish negligence by the Defendant, the Plaintiff must have proved by a preponderance of the evidence, one, the recognized standard of medical care in the community which would be exercised by physicians in the same specialty under similar circumstances and, two, that the physician in suit departed from that standard in his treatment or diagnosis of the Plaintiff.

In this case the crux of the negligence question is whether after a suspicion of hypothyroidism, the Defendant in 1954 should have taken or ordered certain laboratory tests.

The Plaintiff's experts testified that laboratory
306 tests in general are used to confirm clinical diagnoses. This is the extent of their testimony on this point. There is no evidence by any doctor who testified that a laboratory test would be used under the circumstances of this case, and since the Plaintiff's case is based solely on the fact that the Defendant did not order a laboratory test during the period 1954 to 1958, it follows that the Defendant's motion for a directed verdict must be granted for want of any evidence whereby the jury could find negligence.

Members of the jury, that is my view of the case as a matter of law and that is my responsibility. I relieve you of it. And it is my responsibility to direct you to return a verdict in favor of the Defendant.

The clerk will take your verdict.

The Clerk: Jurors, please rise.

Members of the jury, your verdict in this case is for the Defendant, John Alfred Reisinger, by direction of the Court and this is your verdict so say you each and all.

(Whereupon the jury indicated in the affirmative.)